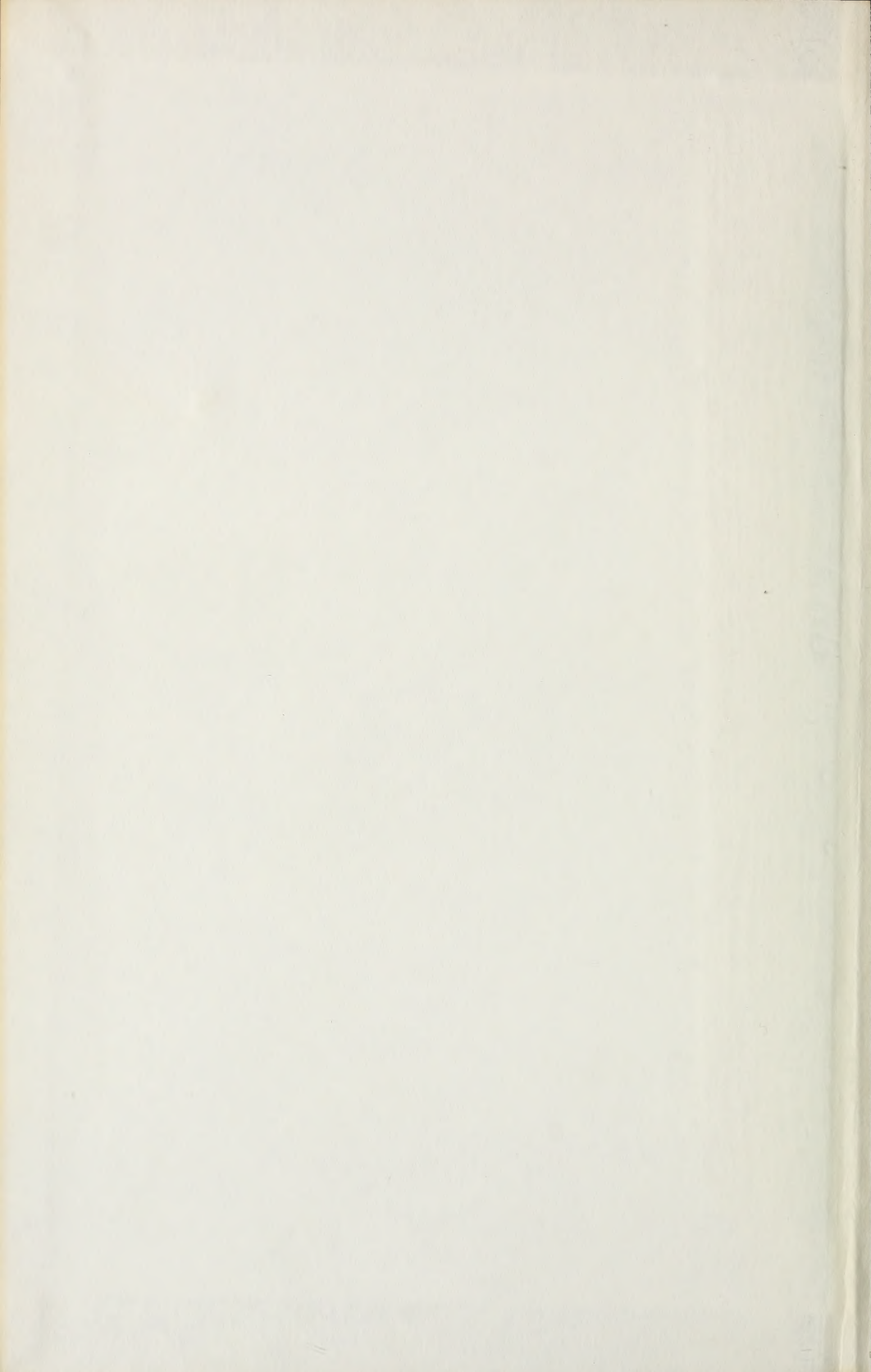
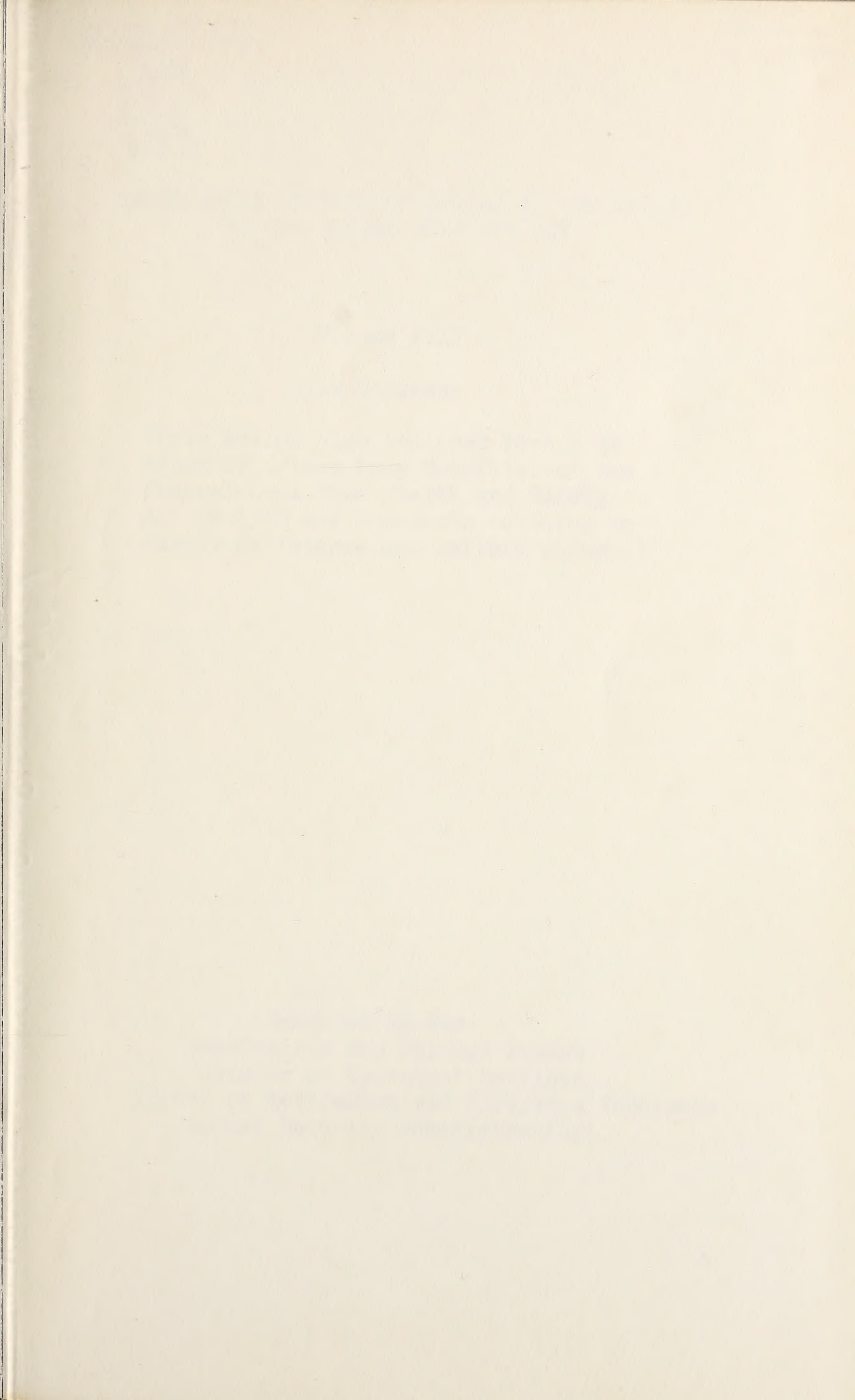


LEGISLATIVE HISTORY
TITLES II AND XVIII
OF THE
SOCIAL SECURITY ACT

VOL. XIII
91st CONGRESS

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LEGISLATIVE HISTORY OF TITLES II AND XVIII
OF THE SOCIAL SECURITY ACT

Volume XIII

91st Congress

(This volume also includes Part B of title IV (Black Lung Benefits) of the Federal Coal Mine Health and Safety Act of 1969 and documents relating to family assistance and welfare reform.)

Compiled by the
Regulations and Rulings Branch
Division of Technical Services
Bureau of Retirement and Survivors Insurance
Social Security Administration

PREFACE

This legislative history has been prepared to provide a convenient reference source for studies of the development of the social security benefit provisions of the Social Security Act.

The legislative history begins with the Social Security Act, as enacted on August 14, 1935, and includes every subsequent enactment affecting, or adding to, the social security benefit provisions administered by the Social Security Administration. In addition, the official reports of the House of Representatives and the Senate, issued with respect to the Social Security Act and each of the subsequent amending acts, as well as certain other House and Senate documents (e.g., analysis of proposed legislation, special reports, etc.), are also included in this legislative history. In most cases, the complete text of the amending public law and accompanying House or Senate report, or document, is contained in this legislative history. However, in the few cases where a public law, report, etc., deals only incidentally with social security legislation and is of exceptional length, only pertinent excerpts are included in this history.

In some instances, the House and Senate reports accompanying a particular act will not reflect one or more provisions contained in the act. This is usually due to the fact that the particular provision was added to the bill on the floor of the House, or Senate, as the case may be, after issuance of the particular report. In these cases, background material relating to the amendment may be found in the Congressional Record report of the House or Senate debate on the bill. The Congressional Record may also provide a useful supplemental reference source even in those cases in which the House or Senate report discusses the particular provision in which the researcher is interested. It is not feasible to reproduce in this legislative history the thousands of pages of the Congressional Record carrying the House and Senate debates with respect to the acts included in the history. However, on the last page of each public law contained in this volume, appears a listing of the dates on which the act was considered in the House and Senate, and the volume of the Congressional Record in which such debate may be found.

This volume also includes Part B of title IV of the Federal Coal Mine Health and Safety Act of 1969. Part B relates to claims for Black Lung Benefits. This volume also includes certain documents relating to family assistance and welfare proposals considered by the 91st Congress.

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Message from the President of the United States transmitting Proposed Reforms in the Social Security System, House of Representatives, Document No. 91-163.

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Public Law 91-669 (H. R. 19915), January 11, 1971, An Act to extend the temporary provision for disregarding income of old-age, survivors, and disability insurance and railroad retirement recipients in determining their need for public assistance.

House of Representatives Report No. 91-1716 to accompany H. R. 19915.

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Social Security, House Document
No. 91-40.



THE RETIREMENT TEST UNDER SOCIAL SECURITY

LETTER

FROM

THE SECRETARY OF HEALTH, EDUCATION,
AND WELFARE

TRANSMITTING

A REPORT RESULTING FROM A STUDY OF THE RETIRE-
MENT TEST PURSUANT TO PUBLIC LAW 90-248, THE
SOCIAL SECURITY AMENDMENTS OF 1967



JANUARY 9, 1969.—Referred to the Committee on Ways and Means,
and ordered to be printed, with illustrations

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1969

LETTERS OF TRANSMITTAL

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., January 7, 1969.

HON. JOHN W. McCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I have the honor to transmit to you a report on "The Retirement Test Under Social Security." The report resulted from a study of the retirement test called for by the Congress in Public Law 90-248, the Social Security Amendments of 1967. The report presents the results of the Department's study.

Over the years there have been considerable confusion and misunderstanding of the retirement test in social security. Many people feel that it should be eliminated from the program, arguing that the beneficiaries have paid for their benefits and should get them as soon as they are otherwise eligible without regard to whether they have retired. This of course is erroneous. What the people have been paying for is a retirement benefit prior to age 72 and an annuity payable automatically at age 72 regardless of whether they are working, not an annuity payable from age 65 on. The idea, then, that people otherwise eligible for social security benefits should get such benefits regardless of the amount of their earnings because they have paid for their benefits is not a soundly based idea. Incidentally, taking the whole group of beneficiaries now on the rolls, they and the employers who have paid contributions on the earnings on which their benefits are based, together, have paid contributions that on the average cover only about 10 percent of the value of the benefits payable on those earnings.

Another misunderstanding that many people have is that a person who works after age 65 is treated unfairly as compared to a person who after retirement has income from savings and investments. People who think this way misunderstand the whole purpose of a retirement system, which is to pay benefits to partially replace lost earnings. If benefits were withheld because the person had income from savings, investments, a private pension plan or the like, the program would discourage people from saving in their productive years to have a more comfortable life in retirement than social security benefits alone can make possible. In fact the partnership that now exists between private pension plans and the social security program would be disrupted if nonwork income were to cause withholding of social security benefits. The 90,000 private pension plans now in effect in the United States have been designed to supplement the social security program, and the benefit levels under those plans take into account the fact that social security benefits will be payable upon retirement to those covered by the plans. If social security benefits were to be withheld because of the receipt of pensions under such plans, the advantages of

the combined Government-private effort in providing adequate retirement benefits would be seriously impaired.

Repeal of the retirement test would increase the cost of the social security program by \$2.5 billion a year now, and more in future years. In order to finance this additional cost it would be necessary to increase social security contributions for employers and employees by a total of 0.70 percent of taxable payroll or by 0.35 percent of taxable payroll each for employers and employees. Most of this additional cost would be incurred in order to pay benefits to people who are fully employed and earning as much as they ever did. I do not believe that this would be the best use of the income available to the social security program and therefore do not recommend repeal of the retirement test.

I am in favor, however, of certain changes in the retirement test. I recommend that the amount a social security beneficiary can earn in a year and still get all of his benefits—now \$1,680—be brought up to date with the increases in earnings levels that have occurred since the present exempt amount was enacted and kept up to date thereafter. This would require an increase in the annual exempt amount to \$1,800 with a corresponding increase from 140 to \$150 (one twelfth of the annual exempt amount) in the monthly exempt amount—the amount of wages which, regardless of his annual earnings, a beneficiary can earn in a given month and still receive his benefit for that month. In order to keep the annual exempt amount in line with changes in earnings levels in the future, I recommend that the law include a provision for automatically adjusting the exempt amount to rises in earnings levels.

In addition to these changes I recommend a change in the provision under which benefits are withheld when the beneficiary's earnings exceed the annual exempt amount. I recommend no change in the provision in present law under which \$1 in benefits is withheld for each \$2 of earnings for the first \$1,200 of earnings above the exempt amount. I do believe, however, that the provision under which \$1 in benefits is withheld for each \$1 of earnings above the \$1,200 \$1-for-\$2 reduction band should be changed so that \$3 in benefits is withheld for each \$4 of such earnings. With an \$1,800 exempt amount the \$3-for-\$4 reduction would apply to earnings above \$3,000.

These changes taken together would increase the cost of the social security program by an estimated 0.07 percent of taxable payroll, and, if effective January 1, 1970 (under existing benefit levels), would result in increased payments of \$285 million to beneficiaries in the first full year of operation.

I urge favorable consideration of these recommendations and their prompt enactment. Attached to the report is a draft of proposed legislation to carry out my recommendations.

Sincerely,

WILBUR J. COHEN, *Secretary.*

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., January 3, 1969.

THE PRESIDENT,
The White House,
Washington, D. C.

DEAR MR. PRESIDENT: I have the honor to transmit to you a report on "The Retirement Test under Social Security." The report resulted from a study of the retirement test called for by the Congress in Public Law 90-248, the Social Security Amendments of 1967. The report presents the results of the Department's study.

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I have urged favorable consideration of these recommendations and their prompt enactment. Attached to the report is a draft of proposed legislation to carry out my recommendations.

Faithfully yours,

WILBUR J. COHEN, *Secretary.*

THE RETIREMENT TEST

UNDER

SOCIAL SECURITY

A REPORT ON A STUDY CALLED FOR BY THE CONGRESS
IN P.L. 90-248, THE SOCIAL SECURITY AMENDMENTS OF
1967

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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THE RETIREMENT TEST UNDER THE SOCIAL SECURITY PROGRAM

A REPORT ON A STUDY CALLED FOR BY THE 90TH CONGRESS IN PUBLIC LAW 90-248, THE SOCIAL SECURITY AMENDMENTS OF 1967

I. INTRODUCTION

The directive of the Congress, which is included in Public Law 90-248, the Social Security Amendments of 1967, that the Department study the retirement test under social security reads:

(a) The Secretary of Health, Education, and Welfare is authorized and directed to study (1) the existing retirement test and proposals for the modification of such test (including proposals for an increase in old-age insurance benefit amounts on account of delayed retirement) * * *.

(b) On or before January 1, 1969, the Secretary shall transmit to the President and the Congress a report which shall contain his findings of fact and any conclusions or recommendations he may have.

A major report on this subject was submitted by the Department in 1960, at the request of the Committee on Ways and Means of the House of Representatives, and gave findings and recommendations on the test as it existed at that time. Generally speaking, the recommendations in that report have been followed and have been instrumental in shaping the test into its present form.

The present study focuses principally on two areas of congressional interest mentioned during consideration of the Social Security Amendments of 1967. The Committee on Ways and Means was particularly interested in the provision under which a person can have substantial earnings in part of the year and still get social security benefits for the remainder of the year. In its report on the 1967 amendments (House Report No. 544) the Committee stated:

While the overall effect of the present retirement test provides generally satisfactory results, it still permits a person to have substantial earnings in part of the year and to receive substantial social security benefits in the remainder of the year. In the course of its deliberations your committee asked the Social Security Administration to give further and more intensive study to this problem.

Senate interest centered on proposals to increase old-age insurance benefits for those workers who continue to work beyond age 65.

II. BACKGROUND

WHY THE LAW CONTAINS A RETIREMENT TEST

In a word-related society a basic problem is the insecurity arising from the interruption of work income, which, of course, affects not only the worker but those members of his family who are dependent

on his earnings. While a combination of approaches, including group and individual insurance plans and government-sponsored programs, are used in the United States for preventing economic insecurity, the old-age, survivors, and disability insurance program—commonly called social security—is the basic mechanism for preventing insecurity arising from interruption in income from work.

Social security is a social insurance system under which workers and their dependents are insured against the loss of work income resulting from the worker's death, disability, or retirement. The benefit payments made when that loss occurs are designed to partially replace the earnings that are lost, and thus to help prevent the economic insecurity that would otherwise result.

Necessary in any insurance system—private or social—is some way to measure whether, and the extent to which, the loss insured against has occurred. One of the mechanisms used in the social security program is the retirement test. The assumption underlying this test is that if a beneficiary's earnings from work are below certain limits, the loss of earnings insured against has occurred, wholly or partly.

The same general assumption applies throughout the social security cash benefit programs. The disability insurance part of the program takes into account, in evaluating disability, not only the medical condition of the beneficiary, but also his earnings, if any, from work. If a disabled beneficiary has substantial earnings from actual work activity, he is not considered to have suffered a loss of work income sufficient to call for the payment of benefits even though his physical condition may be indicative of severe disability. In the survivors insurance part of the program a sufficient loss of work income is not considered to have occurred if the earnings of the survivors are above certain limits.

THE PRESENT RETIREMENT TEST

The present retirement test contains four important elements:¹

1. *An annual test.*—Annual earnings from work up to \$1680 are exempt from the test; a beneficiary whose earnings from work do not exceed \$1680 in a year is considered to be fully retired and gets full benefits for the year.

2. *A two-step reduction in benefits if earnings exceed the annual exempt amount.*—One dollar in benefits is withheld for each \$2 of annual earnings between \$1680 and \$2880 and for each \$1 of earnings above \$2880.

3. *A monthly test.*—Regardless of annual earnings, benefits are payable in full for any month in which a beneficiary neither works for wages of more than \$140 nor renders substantial services in self-employment.

4. *An exemption on account of age.*—Beginning with the month in which a person reaches age 72, benefits are payable to him (and to his eligible dependents) regardless of the amount of his earnings.

Each of these elements sounds relatively simple, but when combined and explained to an elderly and perhaps not too well-educated person

¹ These elements apply to beneficiaries living in the United States and to beneficiaries who work outside the United States in employment covered by social security. For beneficiaries working abroad in noncovered employment or self-employment, the test is related to the number of days worked in a month. Under the foreign work test no benefit is payable for any month in which work is performed on 7 or more calendar days. The foreign test is discussed more fully in another part of the report.

they can be very confusing. It is not unlikely that some people who could and would like to work do not do so because they do not understand the conditions under which they can work and still get benefits.

The test applies only to income from work; benefits are payable regardless of income from investments and other nonwork sources—savings, investments, insurance, and the like. To include nonwork income in the earnings counted for retirement test purposes would be contrary to the purpose of a social insurance system—to insure against loss of earnings from work. Income from nonwork sources generally continues after retirement as it did before; retirement cannot be determined by measuring the presence or absence of nonwork income. Moreover, disincentives for the creation of private pension plans and savings for retirement would result from inclusion of nonwork income under the retirement test. Furthermore, doing so would make the retirement test similar to the means test used to determine eligibility for payments under public assistance programs, and would thus tend to subject the social security program to the same sort of criticisms that have been leveled at the assistance programs. The reasons the retirement test has taken its present, somewhat complicated form will perhaps be easier to understand if the considerations that led to the various changes that have been made in it through the years are reviewed.

Under the original Social Security Act, which was enacted in 1935, monthly benefits were not payable for any month in which a worker received covered wages from “regular employment.” This provision was changed by the 1939 amendments before any monthly benefits were paid.

From 1940, when monthly benefits first became payable, through 1950 the test of retirement applied only to earnings from covered employment. During those years, work as an employee in commerce and industry was, generally speaking, the only employment covered by the program. The test was entirely on a monthly basis; the beneficiary got a full benefit for any month in which he earned less than \$15 in covered employment. In 1951 this monthly exempt amount was increased to \$50.

When self-employed people were brought under the program in 1951, the test of retirement for them was put on an annual basis. (This was necessary because it is impossible in many cases for a self-employed person to compute his earnings on a monthly basis.) Specifically, it was provided that a person with self-employment earnings of \$600 or less for the year could get benefits for all months in the year, no matter what his earnings were in any single month. One month’s benefit was withheld for each \$50 (or part of \$50) of earnings above \$600.

One part of the test for the self-employed, however, was placed on a monthly basis even though the earnings were figured over the whole year. No matter how high his annual earnings, a self-employed beneficiary could get a benefit for any month in which he did not render substantial services in his business. This latter provision served three purposes: First, it placed the self-employed beneficiary on a par with the wage earner—despite the fact that he could determine his earnings only on an annual basis—in that he could get a benefit for any month in which he did not work or in which he worked very little. Second, it allowed the payment of benefits to a self-employed beneficiary for months in which he did no work in the year in which he

retired, even though his total earnings for the year were above the exempt amount by reason of work done before retirement. And third, the provision allowed payment of benefits to a person whose self-employment income came, not from work in operating the business, but rather from the investment he had in the business.

Another modification in the test, effective in 1951, exempted people from the retirement test at age 75. This change was made in recognition of the fact that some people continue working to a very advanced age. Without such an age exemption these people might never get benefits even though they had paid social security contributions longer than most people.

In 1952 the monthly exempt amount for wage earners was raised from \$50 to \$75, the annual exempt amount for self-employed people was raised from \$600 to \$900, and the unit of earnings above the annual exempt amount which caused one month's benefits to be withheld was increased from \$50 to \$75.

Two important criticisms relating to the different treatment given to wage earners and self-employed people under the test soon developed. First, a self-employed person could work, say, for three months, earn up to the annual exempt amount, and still get benefits for the whole year, while the wage earner who worked in three months and had the same total yearly earnings had three months' benefits withheld. Second, a person who had both self-employment income and wages was in an unwarrantedly favorable position because he could meet the two tests separately; that is, he could have earnings from self-employment for the year of as much as the annual exempt amount, and also have wages in every month amounting to as much as the monthly exempt amount, and still get all of his benefits for the year. The 1954 amendments removed these two anomalies by providing that earnings from self-employment and wage employment would be combined for retirement test purposes and by providing for an annual exempt amount (\$1,200) for both the self-employed beneficiary and the wage-earner beneficiary. For each \$80 (or fraction of \$80) of earnings above \$1,200, one month's benefit was withheld.

The 1954 amendments also provided that a wage earner could get a benefit for any month in which he earned no more than \$80, regardless of his earnings for the year. This provision was included partly to avoid situations where a worker would not be able to get benefits under the 1954 amendments although he could have gotten them before. The provision also solved the problem of finding a way to pay benefits for the rest of a year when a worker retired in the middle of the year after his earnings were over the exempt amount. Without the monthly test a worker who retired in July, for example, after earning \$2,500 in that year, could not have gotten benefits for any part of the year.

In addition, the 1954 amendments lowered from 75 to 72 the age at which people are exempt from the retirement test.

The 1958 amendments provide that a beneficiary who earned above \$1,200 in a year would not have a benefit withheld for any month in which he earned wages of \$100 or less (rather than \$80 or less as previously provided), making the monthly test of retirement one-twelfth of the annual exempt amount. This change was made in order to improve public understanding of how the test operated. One of the reasons people had found the test difficult to understand was that having

benefits withheld for months in which earnings exceeded \$80 did not seem to be rationally related to the \$1,200 exempt amount. No change was made at the time in the provision under which one month's benefit was withheld for each \$80, or fraction of \$80, of earnings above \$1,200.

In the course of its consideration of the 1958 social security amendments, the Committee on Ways and Means directed the Department of Health, Education, and Welfare to examine and to report on the monthly exempt amount—the provision that allows a person, regardless of his annual earnings, to get a benefit for any month in which he does little or no work. The Department submitted a comprehensive report in 1960 which not only covered this aspect of the test but also re-examined its other provisions.

The report discussed the need for retaining the monthly test of retirement, giving essentially the same reasons that had prompted its inclusion in the law originally. The report pointed out that it would not seem reasonable to require a person to go through the first several months of retirement without getting benefits, that benefits should start as soon as possible after earnings cease, and that the monthly test of retirement makes this possible. Without the monthly test a person who retired at the end of June, for example, after having substantial earnings would get no benefits for the rest of the year, even though he had no earnings in the remainder of the year. With the monthly test, he loses benefits only for the months in which his earnings exceed the monthly exempt amount. The monthly test also makes it possible for the beneficiary who returns to or leaves employment during the year to get benefits for the months in which he does not have substantial earnings from work.

The report also discussed the deterrent to work that then existed because of the provision under which one month's benefit was withheld for each \$80, or fraction thereof, of earnings in excess of the annual exempt amount. Under this provision it was possible for a family to lose a full month's benefit for as little as \$1 in excess earnings. In this situation the family could suffer a substantial loss in total income as a result of earnings from work. The report suggested that the method of adjusting benefits where earnings exceed the annual exempt amount should be changed to insure that earnings above the exempt amount would not result in a decrease in the combined total income from earnings and benefits.

The 1960 amendments made no change in the monthly test of retirement but did provide a new method of adjusting benefits where earnings exceeded the annual exempt amount. This new adjustment method was along the lines of the proposals included in the report on the retirement test. The amount of benefits to be withheld was to be in proportion to the amount of annual earnings above \$1,200—\$1 to be withheld for each \$2 of earnings between \$1,200 and \$1,500 and for each \$1 of earnings above \$1,500. This basic method of determining the amount of benefits to be withheld, which was adopted to reduce the deterrent to work which existed under the previous test, is still in effect.

The 1961 amendments extended the band of earnings over which the \$1-for-\$2 adjustment of benefits applied by increasing the ceiling on the band from \$1,500 to \$1,700.

The 1965 amendments made no change in the basic structure of the retirement test. The amendments did, however, raise the annual exempt amount from \$1,200 to \$1,500 (with a corresponding increase in the monthly exempt amount to \$125) and provided that the \$1-for-\$2 adjustment band would apply over a \$1,200 range above the exempt amount—that is, from \$1,500 to \$2,700.

Under the 1967 amendments the annual exempt amount was increased to \$1,680, with corresponding increases in the monthly measure to \$140 and in the ceiling of the \$1-for-\$2 adjustment band to \$2,800.

In summary, the social security law has always contained some provision to assure that benefits will be paid only to people who do not have substantial earnings from work—in effect, a test of retirement.

Any test of retirement for social insurance purposes must be a compromise between two conflicting goals. The principle that social insurance benefits should be paid only to those suffering a loss of work income must be balanced with the need to avoid creating disincentives for those who wish to work. The retirement test, then, must be a compromise between these two objectives. While preventing payment of benefits to people with relatively substantial earnings, the amount of earnings allowed without any withholding of benefits should be high enough to allow those beneficiaries who can work at low-paying or part-time jobs to do so and still get part or all of their benefits.

The retirement test as it stands today prevents the payment of benefits to people with substantial earnings from work, but does not prevent payment merely because a beneficiary has some earnings. It thus does not completely remove incentives to work. The present test must be considered a rough approach to the problem of paying benefits when there has been significant loss of income while avoiding disincentives to work—a problem that is much too complex for any simple solution.

One of the difficulties arises because of the tremendous variation in the circumstances of the beneficiaries. It is questionable whether a retirement test geared to each individual case—e.g., one that would pay benefits to a person who during his working lifetime had a \$20,000-a-year job and after “retirement” is able to make \$5,000 a year as a consultant, while denying benefits to a \$6,000-a-year worker who after retirement manages to pick up something more than \$1,500 at odd jobs—would be accepted by the public.

There is no question that the present test is difficult for most beneficiaries—especially the aged—to understand, both as to operation and as to purpose. One result of its complexity is that it is difficult to administer. Because the operation and purpose of the test are widely misunderstood, administration is made even more difficult.

One of the major factors to be considered in evaluating any proposed change in a social insurance program is the cost of the proposed change relative to its potential benefits and relative to the cost of other possible changes in the program. The cost of total elimination of the retirement test for all beneficiaries, including those under 65, is 0.70 percent of taxable payroll—enough to finance a 7-percent across-the-board increase in social security cash benefits.

HOW MANY PEOPLE ARE AFFECTED BY THE RETIREMENT TEST?

The number of people affected by the retirement test is actually quite small when considered as a percentage of the people who are elig-

ible for benefits. As Table 1 indicates, of the 17.9 million people age 65 and older who are eligible for social security cash benefits on January 1, 1969, only 1.4 million—about 8 percent—have any benefits withheld under the retirement test. While it is not possible to determine the exact number of people who are holding their earnings down because of the test, it appears safe to draw some general conclusions on the basis of information that is available.

TABLE 1.—*Old-age, survivors, and disability insurance: Persons aged 65 and over and eligible for social security cash benefits on Jan. 1, 1969, and number affected by the retirement test in 1968*

[In millions]		Number of persons
U.S. population aged 65 and over, Jan. 1, 1969 ¹	-----	19.8
Persons aged 65 and over, eligible for social security cash benefits on Jan. 1, 1969 ²	-----	17.9
Not subject to the retirement test in 1968 ³	-----	8.3
Subject to the retirement test in 1968 ³	-----	9.6
With no earnings for 1968	-----	6.6
With annual earnings for 1968 below \$1,400	-----	1.2
With annual earnings for 1968 of \$1,400 to \$1,680	-----	.3
With annual earnings for 1968 above \$1,680, but with no benefits for 1968 withheld because of the retirement test ⁴	-----	.1
With annual earnings for 1968 above \$1,680, and with some or all benefits for 1968 ⁵ withheld because of the retirement test	-----	1.4
Some, but not all, benefits withheld because of the retire- ment test	-----	.6
All benefits withheld because of the retirement test	-----	.8

¹ Includes Puerto Rico, Virgin Islands, American Samoa, and Guam. Also includes allowance for underenumeration in the census counts on which the population estimate is based.

² Includes spouses aged 65 and over of workers aged 62-64.

³ Generally, persons who attained age 72 in January 1968 or earlier were not subject to the retirement test in 1968; persons who were under age 72 at the end of January 1968 were subject to the retirement test during some or all months in 1968. An exception to this is a spouse who attained age 72 in January 1968 or earlier of a worker who was under age 72 at the end of January 1968—such spouses were subject to retirement test in 1968.

⁴ These are people who attained age 65 in 1968 and who had no benefits withheld for months in or after the month of attainment of age 65, generally because they had either no earnings or earnings not exceeding \$140 a month in such months.

⁵ As used here, "all benefits for 1968" means all of the benefits for all months in 1968 in which an eligible individual is aged 65 or over.

Of the 17.9 million people age 65 and older who are eligible for benefits, 8.3 million are age 72 and older and thus are not subject to the test. An additional 8.1 million are technically subject to the test but earn less than \$1,680, the annual exempt amount under present law. Among these 8.1 million people, 6.6 million have no earnings at all, and another 1.2 million have earnings of less than \$1,400 a year; almost all of the people in these two groups are probably either unable to earn as much as \$1,680 a year (the present exempt amount) or prefer not to work enough to do so.¹

The remaining 300,000 of the 8.1 million people age 65 and older who are technically subject to the test are earning between \$1,400 and \$1,680 and are getting full benefits. Some of these 300,000—probably most of them—are holding their earnings down, either because they

¹ A 1963 survey made by the Social Security Administration showed that a majority of the aged who were not working—both beneficiaries and nonbeneficiaries—were unable to work. Among those who felt they were able to work, the vast majority did not expect to work and were not interested in working.

do not understand the retirement test or because they want to get all of their benefits; many of them would earn more than they do now if the test were repealed or if the \$1,680 exempt amount were increased. Others among the 300,000 no doubt are earning all that they can earn.

There are about 100,000 persons who attained age 65 in 1968 with 1968 earnings above \$1,680 who had no benefits withheld for months in or after the month of attainment of age 65. Generally, this was so because they had either no earnings or earnings not exceeding \$140 a month in such months.

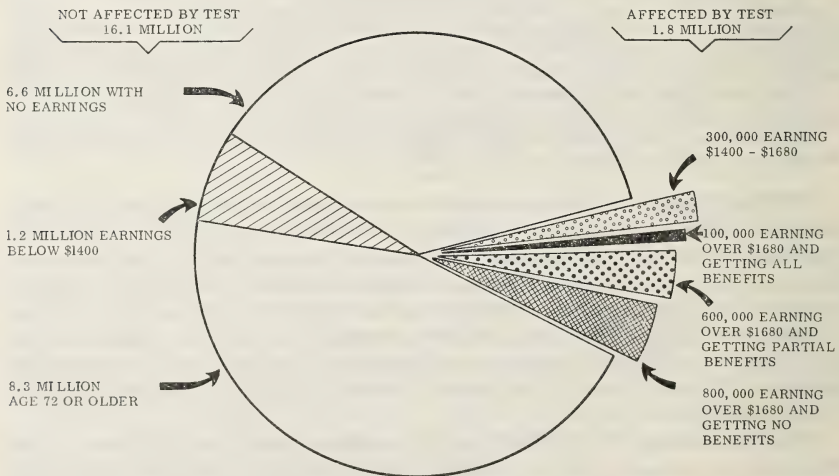
Another group of about 600,000 are earning over \$1,680 and are getting some but not all of their benefits. Presumably most of these people are earning all that they can earn.

The remaining 800,000 people are earning enough over \$1,680 so that no benefits are payable to them. Many of these people undoubtedly are continuing to work and earn as much as they ever did. If the retirement test were eliminated they then could get full benefits without limiting their earnings in any way.

In summary, analysis of the effect of the retirement test on older people indicates that 90 percent of the people eligible for benefits are probably not affected by the test because they are 72 or older or are unable or unwilling to work to any substantial degree. Thus, any change in the test, including its elimination, would not help at all the vast majority of people who are eligible for benefits; the people who would benefit from elimination or liberalization of the retirement test would be those who continue working and earning relatively substantial incomes.

Chart 1

NUMBER OF PEOPLE* AFFECTED BY RETIREMENT TEST IN 1968



*17.9 MILLION ELIGIBLE PEOPLE AGED 65 AND OLDER

(AS OF JANUARY 1, 1969)

III. ANALYSIS OF VARIOUS CHANGES THAT COULD BE MADE IN THE RETIREMENT TEST

THE MONTHLY TEST

Under present law the monthly part of the retirement test permits the payment of benefits, regardless of the amount of annual earnings, for any month in which a person neither earns wages of more than \$140 nor renders substantial services in self-employment. Under this provision a person can have very high earnings in one month and get benefits for the other 11 months of the year. This situation has concerned the Congress, and the Committee on Ways and Means in particular, over the years. The 1960 study of the retirement test was, in fact, prompted by that Committee's interest in the monthly test.

The 1960 report not only presented information on the results of the monthly test as it applied to high wage earners but also considered a special test for people with relatively high earnings. The conclusions were that the monthly test of retirement should be retained and that a separate test for beneficiaries with high earnings would add further complexities to an already complex provision and would, solely on the basis of high earnings over a short time, prevent the payment of benefits to people who were actually retired.

A major function of the monthly test is to make possible the payment of benefits to a retired worker beginning with the first month of his retirement. This allows payments to begin as soon as possible after earnings cease—when the need for benefits arises. Removal of the monthly test would make it impossible in many cases to pay benefits promptly upon retirement. So far as is known, no other retirement system operates in such a way.

The following are examples of what would occur if the monthly test were eliminated:

(a) A person retires at the end of August 1968 after being paid \$4090 in that year. His social security benefit amount is \$150. Because of the monthly test of retirement, his benefit payments begin with September. If there were no monthly test, the first benefit for this person would be paid February 3, 1969, for January of that year. Thus he would have been retired for 5 months before he got a social security benefit.

(b) Since people move in and out of employment after reaching retirement age, the problem is not confined to the year of initial retirement for each beneficiary. A person getting \$135 a month in benefits has a chance to take a job in January paying \$150 a week, and does so, thinking he will be able to keep on working. He no longer gets benefits and spends most or all of his earnings for current living expenses. In June his employer goes out of business, and he is unable to get another job. Since in the first 6 months of the year he has earned \$3900, he would not be able to get benefits for the next 6 months if there were no monthly test of retirement—and he would have no earnings.

On the other hand, there are instances in which the monthly test permits the payment of benefits to some who have not really altered

their work pattern and thus are not really retired. These are people whose work is usually carried on during only a part of the year—people like construction workers, teachers, and resort owners. The following are examples of how this can occur:

(a) A teacher who over all of her working lifetime has worked a 9- or 10-month school term and used the summer for vacation applies for social security retirement benefits at age 65 but does not alter her preretirement work pattern. Under present law she may be eligible for 2 or possibly even 3 months' benefits during the summer.

(b) The self-employed owner of a resort earned his livelihood before age 65 by working 8 months of the year. He did no work from October through January. At age 65 he applies for social security benefits and continues to work his usual 8 months in the year. Without altering his preretirement pattern of work, he can get social security benefits for the 4 months when he does not work.

No good reason related to the purpose of the social security program exists for paying benefits to nonretired teachers or seasonal workers for months in which they do not work. These people have not incurred any loss of income. On the other hand, many workers whose normal work is seasonal do work at other jobs during their off season—in fact, for many this is their normal way of life—and if such a person gives up one of his jobs in his old age he has partially retired. One of the major difficulties, then, is how to distinguish, among people who have done seasonal work, those who are in effect partially retired from those who are not. There is also a question of public acceptance; granted that there is dissatisfaction with the test in its present form, it could be very difficult to explain why, where two people were in identical situations, one could get benefits and the other could not.

Nevertheless various alternatives have been developed to deal with the situation in which a person with relatively high earnings for a few months of the year is able to get retirement benefits for the balance of the year. While it would be possible to solve this problem by establishing a retirement test entirely on an annual basis, the examples given above suggest that any such solution would be undesirable. The nearest approach to a satisfactory alternative is outlined below; the Department does not, however, recommend its adoption.

A SEPARATE RETIREMENT TEST FOR PEOPLE WITH RELATIVELY HIGH EARNINGS

This alternative test would add, on top of the present retirement test, a provision that, no matter how little a person worked in a year, \$1 in benefits would be withheld for each \$2 in annual earnings above an amount equal to the ceiling on earnings that are subject to social security contributions and are counted in figuring benefits (now \$7,800). This provision would prevent a drop in income as a result of an increase in earnings above the ceiling for that year. At the same time it would avoid the payment of benefits to people whose earnings were very high.

The following examples illustrate how this alternative would work:

(a) A famous entertainer retires at age 65 in 1969 and becomes eligible for maximum retirement benefits of \$160.50. He decides to

make a single appearance after his retirement, for which he is paid \$12,000. Under the monthly test in present law he can collect social security benefits for 11 months of the year (\$1,765.50) because he has had no earnings in those months. Under the alternative, an amount equal to one-half of his earnings in excess of \$7,800 (\$2,100) would be withheld from the benefits that would otherwise be payable to him. Since \$2,100 exceeds the \$1,765.50 in benefits otherwise payable, he would receive no benefits for the year.

(b) A corporation executive retires at age 65 at the end of February 1969, having earned \$11,000 in the first two months of the year. Under present law he can collect social security benefits for 10 months of the year (\$1,605, again, as in paragraph *a* above, assuming maximum retirement benefits). Under the alternative, an amount equal to one-half of his earnings in excess of \$7,800 (\$1,600) would be withheld from the benefits otherwise payable. He would receive only \$5 in social security benefits for the balance (10 months) of the year in which he retired.

Table 2 gives other examples of the benefits that would be payable under this alternative.

TABLE 2.—ANNUAL BENEFITS PAYABLE UNDER PRESENT LAW AND UNDER A PROPOSAL TO MODIFY THE MONTHLY TEST ¹ (EXAMPLES ASSUME BENEFICIARY IS GETTING A MONTHLY RETIREMENT BENEFIT OF \$160.50)

		Annual benefits that would be payable if the number of months worked were —										
Annual earnings		1	2	3	4	5	6	7	8	9	10	11
Present law:												
\$7,800 ²		\$1,765.50	\$1,605	\$1,444.50	\$1,284	\$1,123.50	\$963	\$802.50	\$642	\$481.50	\$321	\$160.50
Proposal:												
	\$7,800	1,765.50	1,605	1,444.50	1,284	1,123.50	963	802.50	642	481.50	321	160.50
	\$8,200	1,565.50	1,405	1,244.50	1,084	923.50	763	602.50	442	281.50	121	
	\$8,600	1,365.50	1,205	1,044.50	884	723.50	563	402.50	242	81.50		
	\$9,000	1,165.50	1,005	844.50	684	523.50	363	202.50	42			
	\$9,400	965.50	805	644.50	484	323.50	163	2.50				
	\$9,800	765.50	605	444.50	284	123.50						
	\$10,200	565.50	405	244.50	84							
	\$10,600	365.50	205	44.50								
	\$11,000	165.50	5									
	\$11,400											

¹ \$1 in benefits would be withheld for each \$2 in annual earnings above \$7,800 from months protected by the monthly test under present law; no other change would be made in present law.

² The benefits appearing on this line are the minimum amounts payable under the provisions of present law regardless of how much a beneficiary earns in the year; in cases where the worker has low earnings for the year the benefits payable for the year may be somewhat higher.

It should be pointed out that the alternative would further complicate an already quite complicated provision. And many of the people who would be adversely affected by the provision would be people who are essentially retired within the normal meaning of the word.

THE ANNUAL EXEMPT AMOUNT

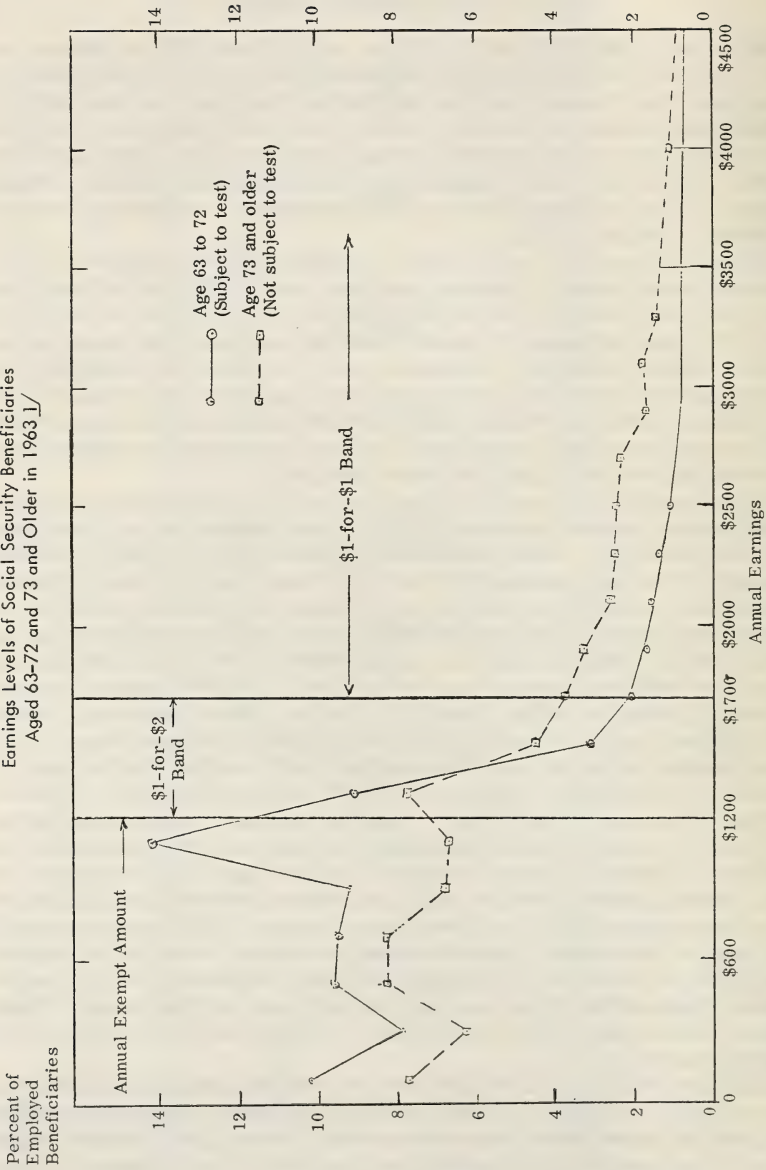
The annual exempt amount—the amount of earnings a person can have in a year without having any benefits withheld—has, over the years, been the element of the retirement test that has elicited the greatest congressional interest. During the 90th Congress, 103 bills were introduced to increase the exempt amount. The interest of the general public has also centered on increasing the annual exempt amount. This provision of the test has been subject to greater pressures for change than any other.

The annual exempt amount has been increased from \$600 in 1951, when an annual exempt amount was first used, to \$1,680 in 1968. Yet, since 1955 the exempt amount has not increased relative to earnings, and in fact has decreased in periods between statutory increases in the amount. Those statutory increases had the effect of bringing the amount back to about 30 percent of the median earnings of male workers. Table 3 shows the relationship between the annual exempt amount and the median annual earnings of all male workers in covered employment in 1940 and in all the years since 1951.

It is impossible to determine the exact amount of earnings that best distinguishes between retirement and nonretirement at a given time. The retirement test, while intended to prevent the payment of benefits to people who have substantial earnings from work, is also intended to interfere as little as possible with incentives to work. Studies indicate that the annual exempt amount has a significant effect on incentives to work. Chart 2, based on a one-percent sample of beneficiaries under the 1963 retirement test (which had a \$1,200 annual exempt amount), illustrates rather forcefully the fact that a substantial number of beneficiaries subject to the test limited their earnings to the annual exempt amount and thus got their full benefits for the year. In contrast, no significant number of people among those not subject to the test—those age 73 and older—was clustered at any particular earnings level. It would appear, then, that the annual exempt amount is a significant factor for many people in planning their work for the year. Probably many people simply do not understand the application of the test to earnings above the exempt amount. Others are no doubt reluctant to earn more than the exempt amount since \$1 in benefits is withheld for each \$2 of earnings in the adjustment band and people consider themselves to be working at half pay in this range. There seems to be no doubt that the greatest deterrent to work occurs at the exempt amount.

A further point is that as the exempt amount is raised, more people can continue working for substantially the same wages after they start getting benefits as they were earning before their benefits began and still get some or all benefits for the year. This happens to some extent under present law, of course, but if the exempt amount were increased it would happen in more cases. For example, a man who qualifies for a benefit based on average yearly earnings of \$4800 and

Chart 2
Earnings Levels of Social Security Beneficiaries
Aged 63-72 and 73 and Older in 1963 1/



1/ Retirement test provided a \$1200 annual exempt amount with \$1 in benefits withheld for each \$2 of earnings between \$1200 and \$1700 and \$1 for each \$1 of earnings above \$1700.

who retires at age 65 in 1969 could—under an annual exempt amount of \$2400 and a \$1-for-\$2 reduction band to \$3600—earn \$4000 a year after retirement and still get \$843.20 in benefits for the year. His income would actually be higher than before he “retired”, and after taxes, this difference would be accentuated, since the \$843.20 in retirement benefits would not be subject to Federal taxes.

Increasing the annual exempt amount to \$2400 would cost 0.29 percent of taxable payroll. Increasing it to \$3600, with a \$1-for-\$2 reduction band to \$4800, would cost 0.64 percent of taxable payroll—about the same cost as abolition of the test for those age 65 and older and enough to finance a general benefit increase of more than 6 percent.¹ Yet the majority of social security beneficiaries are not working, have low earnings, or are age 72 or older. Most of these would not be helped at all by an increase in the exempt amount.

This is not to say, though, that it would be unreasonable to increase the exempt amount from time to time as earnings levels rise. This has been done by the Congress over the years. Based on anticipated increases in earnings in 1969–70, it is estimated that an increase of the annual exempt amount to \$1800 effective in 1970 would maintain the same relationship that existed in 1968 between median annual earnings and the annual exempt amount. An \$1800 annual exempt amount with a \$1200 \$1-for-\$2 adjustment band above that amount would cost 0.05 percent of taxable payroll; an \$1800 exempt amount with an adjustment of \$3-for-\$4 above the \$1-for-\$2 band would cost 0.07 percent of taxable payroll.

AUTOMATIC ADJUSTMENT OF THE EXEMPT AMOUNT

It would be possible, of course, to establish an exempt amount that would not become outdated if earnings levels continue to rise in the future as they have in the past. This could be done by providing for an automatic adjustment of the exempt amount to rises in earnings levels. If the exempt amount were increased under such a provision, a corresponding increase should also be made in the monthly test and in the \$1-for-\$2 adjustment band. Such a change would not require new financing. As earnings levels rise, income to the system increases more than the corresponding benefit liabilities, and the excess of income would more than cover the cost of adjusting the exempt amount.

Table 3 shows how the median earnings of all male workers in employment covered by the social security program have increased since 1940, as well as estimated amounts for future years. During some periods in the past, the exempt amount has not been increased frequently enough to adequately reflect increases in earnings levels. For example, when the \$1200 annual exempt amount became effective in 1955, it was equal to about 36 percent of median annual earnings of male workers in covered employment. This \$1200 amount was not changed until after 1965, when the relationship had dropped to about 26 percent.

¹ If the test were abolished for all social security beneficiaries, rather than only for those age 65 and over, the cost would be 0.70 percent of taxable payroll—enough to finance a benefit increase of 7 percent.

TABLE 3.—COMPARISON OF MEDIAN EARNINGS OF ALL MALE WORKERS IN COVERED EMPLOYMENT WITH EXEMPT AMOUNT OF THE RETIREMENT TEST IN SELECTED YEARS

Year	Median annual earnings of all male workers	Annual exempt amount	Exempt amount as percent of median earnings of all male workers
1940	\$935	\$179.88	19.2
1951	2,838	600.00	21.1
1952	3,046	900.00	29.5
1953	3,275	900.00	27.5
1954	3,263	900.00	27.6
1955	3,315	1,200.00	36.2
1956	3,546	1,200.00	33.8
1957	3,538	1,200.00	33.9
1958	3,516	1,200.00	34.1
1959	3,783	1,200.00	31.7
1960	3,879	1,200.00	30.9
1961	3,936	1,200.00	30.5
1962	4,132	1,200.00	29.0
1963	4,266	1,200.00	28.1
1964	4,480	1,200.00	26.8
1965	4,680	1,200.00	25.6
1966	4,960	1,500.00	30.2
1967 ²	5,250	1,500.00	28.6
1968	5,500	1,680.00	30.5
1969	5,720	1,680.00	29.4
1970	5,980	1,680.00	28.1
1975	7,440	1,680.00	22.6

¹ No annual exempt amount was provided before 1951. The figure shown is 12 times \$14.99 the monthly exempt amount in effect through 1950.

² Figures for years beginning with 1967 are based on estimates of the Social Security Administration.

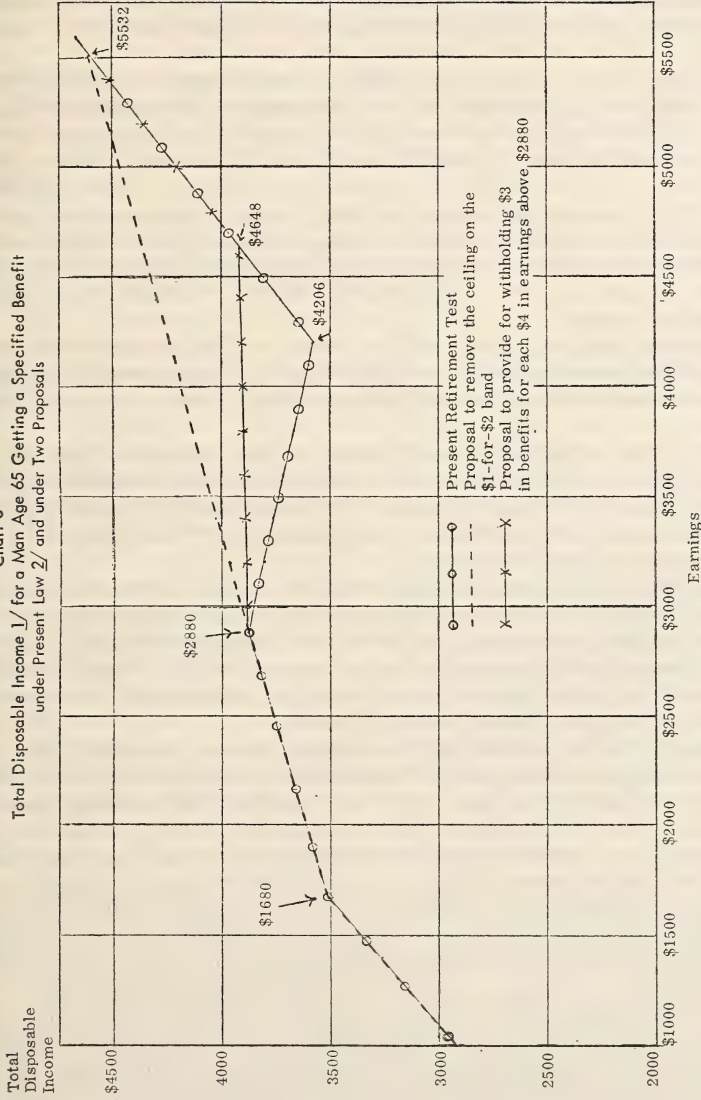
ADJUSTMENT OF BENEFITS WHERE EARNINGS EXCEED THE ANNUAL EXEMPT AMOUNT

Prior to the 1960 amendments, one month's benefit was withheld for each \$80 (or portion thereof) of earnings above the annual exempt amount. Under this method of adjusting benefits above the annual exempt amount, it was possible for a family to have considerably less in total income as a result of the worker's employment, since an amount as small as \$1 could cause a full month's benefits for the family to be withheld. As already noted, this situation was examined in the 1960 retirement test study and recommendations for a change were made. As a result, the 1960 social security amendments provided that \$1 in benefits would be withheld for each \$2 of earnings between the \$1,200 annual exempt amount and \$1,500, and for each \$1 of earnings above \$1,500. This is the basic adjustment method which is used today.

While the 1960 change removed an inequity in the retirement test, it has not been entirely satisfactory. A person's total income can still be reduced because he works and has earnings beyond a given amount, since for each \$1 in taxable earnings above \$2,880, \$1 in tax-free benefits is withheld. Thus, a man who works and earns slightly above \$2,880 will actually have less in total disposable income (benefits plus earnings after taxes) than if he chooses to stop working when he has earned \$2,880.

Chart 3 illustrates the effect of the adjustment band on the disposable income of a man getting a retirement benefit of \$160.50—the maximum benefit amount payable to a man retiring at age 65 in 1969. It should be pointed out that the example shown in the chart does not take account of State or local taxes nor expenses incidental to work. Also, the 10-percent increase in Federal income taxes, because of its temporary nature, has not been included. These factors would further reduce the amount of disposable income.

Chart 3
Total Disposable Income 1/ for a Man Age 65 Getting a Specified Benefit
under Present Law 2/ and under Two Proposals



1/ Total disposable income is social security benefits payable after a retirement test is applied, plus wages after social security contributions (using 1969 rates) and Federal income taxes are withheld. The income tax is computed for a 65 year old single man with standard deductions and does not include the 10 percent surtax. The social security benefit used is \$160.50, the maximum benefit payable to a male worker who is age 65 in 1969.

2/ Under present law, the amount of earnings a beneficiary can have in a year and still get full benefits is \$1680. If earnings exceed \$1680, \$1 in annual benefits is withheld for each \$2 of earnings between \$1680 and \$2880 and for each \$1 of earnings above \$2880.

Extending somewhat the upper limit of the \$1-for-\$2 reduction band would alleviate the situation, since fewer people would be adversely affected, but it would not eliminate the possibility of a person's having less total disposable income as a result of working. The effect of such a change would merely be to raise the point at which the anomaly occurs. If the \$1-for-\$2 band in present law were extended from \$1,200 to, say, \$1,800, the worker with low or average earnings would gain by working, but the worker with higher earnings would not.

To eliminate the problem, it would be necessary to provide for applying another adjustment ratio for earnings above \$2,880—for example, withholding \$3 in benefits for each \$4 of earnings above \$2,880, or extending the \$1-for-\$2 range to all earnings above the exempt amount. A \$3-for-\$4 adjustment for earnings above \$2,880 would cost 0.02 percent of taxable payroll. Such a change would generally assure that a person who had earnings above \$2,880 would break even, rather than suffer a reduction in disposable income as under present law. Chart 3 shows the effect a \$3-for-\$4 reduction would have on disposable income.

On the other hand, as illustrated by Chart 3, if the present \$1-for-\$2 adjustment band were extended without limit, a person would almost always be assured of an increase in disposable income as a result of working.

Since the same adjustment would apply to any amount of earnings, a straight \$1-for-\$2 provision would make the test somewhat less complicated than it is now. However, it would result in benefit payments to some people with relatively high earnings. This change would cost 0.03 percent of taxable payroll.

Liberalizing the adjustment band either by extending the \$1-for-\$2 band or adding a \$3-for-\$4 band on top of it will not help people with low annual earnings—earnings under \$2,880. It seems advisable, then, that an increase in the annual exempt amount, which would benefit those among the lower-paid who can work, be considered in conjunction with any change in the adjustment band.

As discussed in the section on the annual exempt amount, there is a strong tendency on the part of beneficiaries not to earn above the annual exempt amount unless they have substantial earnings above that amount. Chart 2 indicates that the annual exempt amount appears to have much greater significance for beneficiaries than the other provisions of the retirement test. It seems unlikely that any significant percentage of beneficiaries would be induced to substantially increase their earnings above the exempt amount regardless of any change made in the provisions for determining the amount of benefits to be withheld above the exempt amount. The basic reason for making such a change is to assure that a person's income would generally not decrease as a result of working. Withholding \$3 in benefits for each \$4 in earnings above the upper limit of the \$1-for-\$2 band would be a relatively inexpensive way (0.02 percent of taxable payroll) to assure that a person's income would generally not be decreased as a result of his work.

THE AGE AT WHICH THE TEST CEASES TO APPLY

The Social Security Amendments of 1950 modified the retirement test to provide that people age 75 and older could get benefits regardless of the amount of their earnings; prior to that time the test was applied without regard to age. The age was reduced to 72 by the 1954 amendments. Although congressional interest in changing the retirement test has focused on an increase in the annual exempt amount, there has also been some congressional interest in lowering the age at which people are not subject to the test.

The reason the retirement test no longer applies when a person reaches an advanced age is stated in the report of the Senate Committee on Finance on the Social Security Amendments of 1954, as follows:

Under present law, persons age 75 and over are exempted from the retirement test primarily as a means of assuring some return on contributions for people who continue working to a very advanced age and who would otherwise draw very little, if any, payment under the system.

And, of course, since most people do not work to these ages, suspending the test at age 75 and even at age 72 was relatively inexpensive. A further lowering of the age at which a person is exempt from the test might reduce somewhat the negative reaction that the test engenders. The retirement test is sometimes interpreted to mean that the Government does not want social security beneficiaries to work, and many people, including some who are not really affected by the test, resent what they consider an unwarranted restriction. If the age at which benefits could be paid regardless of earnings were lowered from age 72, there would perhaps be less objection on this ground.

On the other hand, the lower the age at which benefits are paid regardless of earnings, the more people there will be who are working and getting benefits, and therefore, of course, the higher the cost. To lower from 72 to 70 the age at which a person would be exempted from the test would cost 0.11 percent of taxable payroll; to lower it from 72 to 68 would cost 0.26 percent.

On balance, the Department believes that, because of the substantial additional cost that would be incurred, a proposal to lower the age at which the test no longer applies should have low priority.

A VARIABLE EXEMPT AMOUNT

Another possible approach to amending the retirement test would be to provide a variable exempt amount. Several bills were introduced by members of the 90th Congress to provide a higher annual exempt amount for people who get low benefits.

The intent of this type of proposal is to allow a person who has been dependent on covered earnings over all or most of his working lifetime, and who because of low earnings is getting low benefits, to earn more without having any benefits withheld than a person getting high benefits. Since the workers getting benefits in the lower ranges presumably have less margin for reduction in their income than do those getting higher benefits, it has been argued that those getting low benefits should be allowed more leeway to supplement their benefits than those who get high benefits.

One proposed change would provide that the annual exempt amount would be equal to \$2,880 (the point in present law at which the withholding of \$1 in benefits for each \$1 in earnings begins to take effect) less the annual benefit amount. If the exempt amount determined in this manner were less than the \$1,680 annual exempt amount in present law, the provisions of present law would apply. The \$1-for-\$2 band would extend over the first \$1,200 above the annual exempt amount as determined above, and \$1 in benefits would be withheld for each \$1 of earnings thereafter.

This proposal would, in effect, provide a variable exempt amount which would always be higher than the exempt amount under present law for people getting benefits of less than \$1,200 a year; for those getting benefits of \$1,200 a year or more, there would be no change from present law. A man with a monthly benefit amount of \$100 (\$1,200 a year) could, as under present law, have earnings of \$1,680 in a year (\$2,880 minus \$1,200) before any benefits would be withheld. A man who had a monthly benefit of \$90 (\$1,080 a year) could have earnings of \$1,800 (\$2,880 minus \$1,080) before any benefits would be withheld.

The basic objection to this type of change is that it would probably not accomplish its purpose. Since social security benefits are based on average earnings, most people who have worked regularly in covered employment during most of their working lifetime and who get low benefits do so primarily because they had low earnings before retirement. But if they could not earn more before retirement, it is quite unlikely that they could do so afterwards. A man aged 65 retiring in 1969 whose benefit was based on average annual earnings of \$1,200 would get benefits of \$858 a year; he would, under this proposal, have earnings up to \$2,022 (\$2,880 less \$858) and still get all of his benefits for the year; but if he could earn \$2,000 a year, he would in all likelihood have been earning that much before retirement. It seems reasonable to assume that most people who continue to work after "retirement" will not earn more than they earned before, in which case the proposal would be of no help to them. Among those for whom this particular variable exempt amount would be of no benefit are people whose average annual earnings are at the level of \$3,328, the lowest wage now payable to a full-time worker under the minimum wage law.

The people who would benefit under the proposal would generally be those whose major employment was in noncovered work—Federal employees, for example—and who qualified for low social security benefits through part-time work. They could, after retirement from their major employment, get social security benefits—and probably other public retirement benefits—and at the same time work for substantial earnings.

If a variable exempt amount were provided, it would seem more logical to allow a person who had high earnings before retirement to earn more and get full social security benefits than a person who had low earnings before retirement, since a high earner who significantly cuts his preretirement earnings—say to 25 percent—might be considered as retired as a low earner who cuts his preretirement earnings by the same percentage. For example it could be argued that a person who reduces his preretirement earnings of \$20,000 per year to \$5,000 per year is just as retired as a person who reduces his preretirement earnings from \$4,000 to \$1,000. But the general public would find it hard to under-

stand, even though it does make sense in a wage-related system, why people getting higher social security benefits could earn more than those getting lower benefits. In effect, there would appear to be a special retirement test favoring one group of beneficiaries—the more fortunate group—over the less fortunate group.

The Department recommends against providing any type of variable exempt amount under the retirement test.

SPECIAL PROVISIONS FOR CERTAIN GROUPS

Proposals under which certain employee groups or specific categories of beneficiaries would be exempt from the retirement test have been made, and a few bills to exempt specific groups from the test were introduced in the last Congress. Groups which have been suggested for exemption include widowed mothers with children in their care and people who work in certain jobs that contribute to the general welfare or who are in labor-short industries.

There is no doubt that in many cases a widowed mother with children in her care, who upon the death of the father of the family is faced with added responsibilities and less-than-normal income, has problems meeting her living expenses. It should be noted, though, that even if the widowed mother works, the children will continue to get their benefits. Moreover, the economic situation of most other social security beneficiaries is in general no better than that of widowed mothers. Although it would be relatively inexpensive to eliminate the test for any small group—for example, 0.04 percent of taxable payroll for mothers—it would be difficult to justify eliminating the test for that group and not doing the same for other groups, many of whom are faced with equal or greater financial difficulties.

Proposals that certain occupational groups be exempted from the test are made on the basis that they would help alleviate manpower shortages in occupations that are essential to the national interest. The idea, of course, is that people who work in hard-to-fill occupations, such as teaching and work in the field of health services, should have their income from such jobs excluded from the retirement test in order that they will continue to work.

The task of determining which occupational groups should be exempted from the retirement test would be a difficult one, and there does not appear to be any agreement in this area. Furthermore, it is questionable whether exemption from the retirement test would have any really significant effect on filling such jobs. People employed in occupations that were exempted from the retirement test would undoubtedly be encouraged to continue work after retirement age, since they could draw full benefits in addition to their regular work income. But it would be extremely difficult, if not impossible, to determine to what extent exemption from the test would influence workers of retirement age who were not employed in these hard-to-fill positions to seek training in these occupations, or to what extent opportunities would be available to them. A \$3-for-\$4 band in place of the \$1-for-\$1 band in present law would assure that a beneficiary would not have less in disposable income as a result of working for earnings above \$2,880 than if he limited his earnings to \$2,880 and therefore would not discourage people from continuing to work. At the same time it would not favor one group of beneficiaries over others.

IV. A DELAYED RETIREMENT CREDIT

As mentioned earlier, the Congress specifically directed the Department, as a part of its study of the retirement test, to examine proposals to pay increased retirement benefits to people who delay retirement beyond age 65.

Under the provisions of present law a worker's retirement benefit is based on his average monthly earnings over a specified number of years; the period used is generally 5 less than the number elapsing after 1950, or age 21, if later, and up to the year in which the worker reaches age 65 (62 for a woman). The law also provides that if he has years of higher earnings after age 65 (62 for a woman), these earnings can be substituted for years of no earnings or years of lower earnings before that age in figuring his average monthly earnings, thereby providing for him a higher benefit amount than would otherwise be possible. Thus a worker who has higher covered earnings after retirement age than he had in earlier years does get higher social security benefits because of his earnings after retirement age. This provision is especially helpful for people who earn above the maximum amount creditable under social security—at present \$7800 a year; when the amount of earnings that can be credited toward benefits is increased, a person continuing to work after 65 (62 for a woman) for annual earnings of more than were previously covered can substitute these years for earlier years in which less of his earnings could have been credited.

But some people who postpone retirement beyond age 65—or who interrupt their retirement to return to work—get benefits no larger than if they had retired at age 65, despite their additional contributions and the fact that they have foregone benefits for some months. Many people resent this. It has been argued that as a matter of equity people who work after 65 should get higher benefits when they do retire.

The argument for providing a delayed retirement credit as a matter of equity carries weight only when it is used relative to two people of the same age who began working under the program at the same time. Not all people who continue to work after age 65 have contributed for a longer period than those who stop work at 65. A person can get a full-rate benefit even though he had no work in covered jobs before 1956. With a delayed retirement credit he would get additional benefits if he worked after age 65 even though he had worked under social security for relatively few years; yet a person of the same age who had contributed to the program since 1937 but who had to retire at age 65 would not get any additional benefits.

A major consideration regarding a delayed retirement credit is its cost. If the credit were large enough to compensate the average person who works beyond age 65 for benefits he would have been paid if he had retired at age 65, the benefit amount payable would have to be increased by approximately 8 percent for each year of delayed retirement. The cost of paying these higher benefits to people age 65 and over would be about 0.65 percent of taxable payroll—the same as the cost of abolishing the retirement test for people age 65 and older. A credit of 4 percent for each year of delayed retirement would cost 0.32 percent. Table 4 gives examples of the benefits that would be payable under various delayed retirement credit proposals.

The objective of paying higher social security benefits for all those who work after age 65 has merit, although there are arguments against it. To do so would incur a high cost, yet those most likely to be affected to any significant degree by the credit would be people who were able to get, or keep, jobs that pay rather substantial wages. In a program designed to provide a partial replacement of lost earnings there does not seem to be any good rationale for providing, at considerable expense, a higher replacement for people who are able to continue working or to get jobs after age 65 than can be paid to people who have had to quit working at age 65. On the other hand, it is true, of course, that providing additional benefits for continued work after age 65 would increase public acceptance of the program, especially among people who work after age 65. The Department believes, though, that any delayed retirement credit should have a relatively low priority until benefit levels have been substantially improved.

TABLE 4.—EXAMPLES OF MONTHLY BENEFITS PAYABLE TO A MAN AGE 65 IN 1968 UNDER PRESENT LAW AND UNDER 4 PROPOSALS FOR A DELAYED RETIREMENT CREDIT¹

Year of retirement	Monthly benefit amount				
	Present law	With annual credit equal to ² —			
		3 percent (a)	4 percent (b)	6 percent (c)	8 percent (d)
1968.....	\$156.00				
1969.....	162.80	\$167.70	\$169.40	\$172.60	\$175.90
1970.....	168.40	178.60	181.90	188.70	195.40
1971.....	174.10	189.80	195.00	205.50	215.90
1972.....	179.70	201.30	208.50	222.90	237.20
1973.....	184.20	211.90	221.10	239.50	257.90
1974.....	189.90	224.10	235.50	258.30	281.10
1975.....	195.00	236.00	249.60	276.90	304.20

¹ Examples assume maximum earnings creditable for social security purposes each year. From 1937 to 1950, the maximum creditable earnings were \$3,000. This amount was raised to \$3,600 in 1951, to \$4,200 in 1955, to \$4,800 in 1959, to \$6,600 in 1966, and to \$7,800 beginning in 1968. Examples also assume that the man retires in January of the year shown.

² Under proposal (a) benefits computed under the existing provisions of the law would be increased by $\frac{1}{4}$ of 1 percent for each month for which a full benefit is withheld under the retirement test; under (b) by $\frac{1}{3}$ of 1 percent; under (c) by $\frac{1}{2}$ of 1 percent, and under (d) by $\frac{3}{4}$ of 1 percent. The latter is the amount needed to fully compensate a worker for benefits that could have been paid if he had not worked after reaching age 65.

V. THE FOREIGN WORK TEST

Prior to 1955, the retirement test applied only to earnings in work covered under the social security program; people who worked in non-covered employment could continue to draw their social security benefits regardless of their earnings. Thus, most beneficiaries working outside the United States were not subject to the retirement test. The 1954 amendments provided that earnings from any type or employment or self-employment in the United States, whether or not covered, were to be taken into account in determining whether benefits should be withheld. However, earnings from noncovered work outside the United States were excluded in determining total earnings for the annual retirement test. Instead, a separate test was devised for beneficiaries who worked in noncovered jobs outside the United States. Under this test benefits are withheld for any month in which a beneficiary engages in noncovered remunerative activity (either employment or self-employment) outside the United States on 7 or more different calendar days.

The chief reason for having a time test was that differences in the values of foreign currencies would have made it practically impossible to maintain parity between domestic and foreign beneficiaries if a money test were used. Whereas a specific amount of earnings derived from a particular trade in one country might represent full-time work, the same earnings in another country might be indicative of only part-time employment.

The domestic retirement test, phrased as it is in terms of dollars, has been updated over the years to bring it into accord with changing economic conditions. There obviously has not been the same need to update the 7-day foreign work test. Nevertheless the question has been raised whether improvements might be made in the foreign work test. Work as an employee under this test has been interpreted to include not only the actual performance of services, but the employment relationship itself. Thus an employee is considered to be working if, under an employment relationship, the performance of services is contemplated or the employee has agreed to be available for work.

For those people who work and earn substantial amounts, the 7-day work test is reasonably equitable. There are, however, certain categories of beneficiaries who, although they earn very little, are adversely affected by the 7-day test—apprentices and small farmers, for example. The Department is continuing to study these situations to determine what, if any, changes should be made in the provisions of the foreign work test; it has no proposals to make at this time.

APPENDIXES

APPENDIX A

COST OF RETIREMENT TEST PROPOSALS

Annual exempt amount	Proposal		Cost as percent of payroll
	Monthly test	Adjustment for earnings above exempt above	
1. \$1,740.....	\$145	\$1 for \$2 for 1st \$1,200 (to \$2,940), \$1 for \$1 above \$2,940.	0.03
2. \$1,800.....	150	\$1 for \$2 for 1st \$1,200 (to \$3,000), \$1 for \$1 above \$3,000.	.05
3. \$1,800.....	150	\$1 for \$2 for 1st \$1,200 (to \$3,000), \$3 for \$4 above \$3,000.	.07
4. \$1,800.....	150	\$1 for \$2 above \$1,800.....	.08
5. \$2,100.....	175	\$1 for \$2 for 1st \$1,200 (to \$3,300), \$1 for \$1 above \$3,300.	.17
6. \$2,400.....	200	\$1 for \$2 for 1st \$1,200 (to \$3,600), \$1 for \$1 above \$3,600.	.29
7. \$3,600.....	300	\$1 for \$2 for 1st \$1,200 (to \$4,800), \$1 for \$1 above \$4,800.	.64
8. Eliminate test for mothers.....			.04
9. Eliminate test for children.....			.01
10. Eliminate test at age 70.....			.11
11. Eliminate test at age 68.....			.26
12. Eliminate test at age 65.....			.65
13. Eliminate test entirely.....			.70

APPENDIX B

Cost of delayed retirement credit proposals

<i>Proposal</i>	<i>Cost as percent of payroll</i>
1. Delayed retirement credit of $\frac{1}{4}$ of 1 percent of the worker's benefit amount for each month retirement is delayed beyond age 65. Dependents' benefits would be increased proportionately-----	0. 24
2. Same as No. 1 except credit is $\frac{1}{3}$ of 1 percent for each month-----	. 32
3. Same as No. 1 except credit is $\frac{1}{2}$ of 1 percent for each month-----	. 48
4. Delayed retirement credit large enough to compensate for the full amount of benefits foregone by delaying retirement beyond age 65 ($\frac{2}{3}$ of 1 percent for each month), with corresponding increase in dependents' benefits-----	. 65

APPENDIX C

DRAFT OF PROPOSED LEGISLATION

A BILL To amend title II of the Social Security Act to increase the amount of earnings permitted each year without deductions from benefits thereunder

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) paragraphs (1), (3), and (4) (B) of section 203(f) of the Social Security Act are each amended by striking out "\$140" and inserting in lieu thereof "\$150 or the exempt amount (determined as provided in paragraph (8) of this subsection)."

(b) Paragraph (1) (A) of section 203(h) of such Act is amended by striking out "\$140" and inserting in lieu thereof "\$150 or the exempt amount (determined as provided in paragraph (8) of subsection (f) of this section)".

(c) Paragraph (3) of section 203(f) of such Act is further amended by striking out "except that of the first \$1,200 of such excess (or all such excess if it is less than \$1,200), an amount equal to one-half thereof shall not be included." and inserting in lieu thereof the following: "except that there shall not be included in such excess—

"(A) 50 percent of the first \$1,200 of such excess (or 50 percent of all of such excess if it is less than \$1,200), and

"(B) (if such excess is greater than \$1,200) 25 percent of the difference between such excess and \$1,200."

(d) Subsection (f) of section 203 of such Act is amended by adding at the end thereof the following new paragraph:

"(8) (A) Between July 1 and November 1 of 1971 and each odd-numbered year thereafter, the Secretary shall determine and promulgate the exempt amount (as defined in subparagraph (B)) for each month in the taxable years ending (i) in the next succeeding odd-numbered year and (ii) in the year following the year specified in clause (i).

"(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the highest:

"(i) the product of \$150 and the ratio of (I) the average taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which a determination under subparagraph (A) is made to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1970; such product, if not a multiple of \$10, shall be rounded to the nearest multiple of \$10, or

"(ii) the exempt amount for each month in the taxable year beginning in the year preceding the year specified in clause (i) of subparagraph (A), or

"(iii) \$150."

(e) The amendments made by this Act shall apply with respect to taxable years ending after December 1969.

Message from The President of
the United States transmitting
Proposed Reforms in the Social
Security System, House of Repre-
sentatives, Document No. 91-163.



REFORMS IN SOCIAL SECURITY

M E S S A G E

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

PROPOSED REFORMS IN THE SOCIAL SECURITY SYSTEM

SEPTEMBER 25, 1969.—Referred to the Committee on Ways and Means
and ordered to be printed

To the Congress of the United States:

This nation must not break faith with those Americans who have a right to expect that Social Security payments will protect them and their families.

The impact of an inflation now in its fourth year has undermined the value of every Social Security check and requires that we once again increase the benefits to help those among the most severely victimized by the rising cost of living.

I request that the Congress remedy the real losses to those who now receive Social Security benefits by increasing payments by 10 per cent.

Beyond that step to set right today's inequity, I propose that the Congress make certain once and for all that the retired, the disabled and the dependent never again bear the brunt of inflation. *The way to prevent future unfairness is to attach the benefit schedule to the cost of living.*

This will instill new security in Social Security. This will provide peace of mind to those concerned with their retirement years, and to their dependents.

By acting to raise benefits now to meet the rise in the cost of living, we keep faith with today's recipients. By acting to make future benefit raises automatic with rises in the cost of living, we remove questions about future years; we do much to remove this system from

biennial politics; and we make fair treatment of beneficiaries a matter of certainty rather than a matter of hope.

In the 34 years since the Social Security program was first established, it has become a central part of life for a growing number of Americans. Today approximately 25 million people are receiving cash payments from this source. Three-quarters of these are older Americans; the Social Security check generally represents the greater part of total income. Millions of younger people receive benefits under the disability or survivor provisions of Social Security.

Almost all Americans have a stake in the soundness of the Social Security system. Some 92 million workers are contributing to Social Security this year. About 80 per cent of Americans of working age are protected by disability insurance and 95 per cent of children and mothers have survivorship insurance protection. Because the Social Security program is an essential part of life for so many Americans, we must continually re-examine the program and be prepared to make improvements.

Aiding in this Administration's review and evaluation is the Advisory Council on Social Security which the Secretary of Health, Education and Welfare appointed in May. For example, I will look to this Council for recommendations in regard to working women; changing work patterns and the increased contributions of working women to the system may make present law unfair to them. The recommendations of this Council and of other advisers, both within the Government and outside of it, will be important to our planning. As I indicated in my message to the Congress on April 14, improvement in the Social Security program is a major objective of this Administration.

There are certain changes in the Social Security program, however, for which the need is so clear that they should be made without awaiting the findings of the Advisory Council. The purpose of this message is to recommend such changes.

I propose an across-the-board increase of 10% in Social Security benefits, effective with checks mailed in April 1970, to make up for increases in the cost of living.

I propose that future benefits in the Social Security system be automatically adjusted to account for increases in the cost of living.

I propose an increase from \$1680 to \$1800 in the amount beneficiaries can earn annually without reduction of their benefits, effective January 1, 1971.

I propose to eliminate the one-dollar-for-one-dollar reduction in benefits for income earned in excess of \$2880 a year and replace it by a one dollar reduction in benefits for every two dollars earned, which now applies at earnings levels between \$1680 and \$2880, also effective January 1, 1971.

I propose to increase the contribution and benefit base from \$7800 to \$9000, beginning in 1972, to strengthen the system, to help keep future benefits to the individual related to the growth of his wages, and to meet part of the cost of the improved program. From then on, the base will automatically be adjusted to reflect wage increases.

I propose a series of additional reforms to ensure more equitable treatment for widows, recipients above age 72, veterans, for persons disabled in childhood and for the dependent parents of disabled and retired workers.

I emphasize that the suggested changes are only first steps, and that further recommendations will come from our review process.

The Social Security system needs adjustment now so it will better serve people receiving benefits today, and those corrections are recommended in this message. The system is also in need of long-range reform, to make it better serve those who contribute now for benefits in future years, and that will be the subject of later recommendations.

The Benefit Increase

With the increase of 10%, the average family benefit for an aged couple, both receiving benefits, would rise from \$170 to \$188 a month. Further indication of the impact of a 10 per cent increase on monthly benefits can be seen in the following table:

	Present minimum	New minimum	Present maximum	New maximum
Single person (a man retiring at age 65 in 1970).....	\$55. 00	\$61. 00	\$165. 00	\$181. 50
Married couple (husband retiring at age 65 in 1970).....	82. 50	91. 50	247. 50	272. 30

The proposed benefit increases will raise the income of more than 25 million persons who will be on the Social Security rolls in April, 1970. Total budget outlays for the first full calendar year in which the increase is effective will be approximately \$3 billion.

Automatic Adjustments

Benefits will be adjusted automatically to reflect increases in the cost of living. The uncertainty of adjustment under present laws and the delay often encountered when the needs are already apparent is unnecessarily harsh to those who must depend on Social Security benefits to live.

Benefits that automatically increase with rising living costs can be funded without increasing Social Security tax rates so long as the amount of earnings subject to tax reflects the rising level of wages. Therefore, I propose that the wage base be automatically adjusted so that it corresponds to increases in earnings levels.

These automatic adjustments are interrelated and should be enacted as a package. Taken together they will depoliticize, to a certain extent, the Social Security system and give a greater stability to what has become a cornerstone of our society's social insurance system.

Reforming the System

I propose a series of reforms in present Social Security law to achieve new standards of fairness. These would provide:

1. *An increase in benefits to a widow who begins receiving her benefit at age 65 or later.* The benefit would increase the current 82½% of her husband's benefit to a full 100 %. This increased benefit to widows would fulfill a pledge I made a year ago. It would provide an average increase of \$17 a month to almost three million widows.

2. *Non-contributory earnings credits of about \$100 a month for military service* from January, 1957 to December, 1967. During that period, individuals in military service were covered under Social Security but credit was not given for "wages in kind"—room and board, etc. A law passed in 1967 corrected this for the future, but the

men who served from 1957 (when coverage began for servicemen) to 1967 should not be overlooked.

3. *Benefits for the aged parents of retired and disabled workers.* Under present law, benefits are payable only to the dependent parents of a worker who has died; we would extend this to parents of workers who are disabled or who retire.

4. *Child's insurance benefits for life* if a child becomes permanently disabled before age 22. Under present law, a person must have become disabled before age 18 to qualify for these benefits. The proposal would be consistent with the payment of child's benefit to age 22 so long as the child is in school.

5. *Benefits in full paid to persons over 72*, regardless of the amount of his earnings in the year he attains that age. Under present law, he is bound by often confusing tests which may limit his exemption.

6. *A fairer means of determining benefits payable on a man's earnings record.* At present, men who retire at age 62 must compute their average earnings through three years of no earnings up to age 65, thus lowering the retirement benefit excessively. Under this proposal, only the years up to age 62 would be counted, just as is now done for women, and three higher-earning years could be substituted for low-earning years.

Changes in the Retirement Test

A feature of the present Social Security law that has drawn much criticism is the so-called "retirement test," a provision which limits the amount that a beneficiary can earn and still receive full benefits. I have been much concerned about this provision, particularly about its effects on incentives to work. The present retirement test actually penalizes Social Security beneficiaries for doing additional work or taking a job at higher pay. This is wrong.

In my view, many older people should be encouraged to work. Not only are they provided with added income, but the country retains the benefit of their skills and wisdom; they, in turn, have the feeling of usefulness and participation which employment can provide.

This is why I am recommending changes in the retirement test. Raising the amount of money a person can earn in a year without affecting his Social Security payments—from the present \$1680 to \$1800—is an important first step. But under the approach used in the present retirement test, people who earned more than the exempt amount of \$1680, plus \$1200, would continue to have \$1 in Social Security benefits withheld for every \$1 they received in earnings. A necessary second step is to eliminate from present law the requirement that when earnings reach \$1200 above the exempt amount, Social Security benefits will be reduced by a full dollar for every dollar of added earnings until all his benefits are withheld; in effect, we impose a tax of more than 100% on these earnings.

To avoid this, I would eliminate this \$1 reduction for each \$1 earned and replace it with the same \$1 reduction for each \$2 earned above \$3000. This change will reduce a disincentive to increased employment that arises under the retirement test in its present form.

The amount a retired person can earn and still receive his benefits should also increase automatically with the earnings level. It is sound policy to keep the exempt amount related to changes in the general level of earnings.

These alterations in the retirement test would result in added benefit payments of some \$300 million in the first full calendar year. Approximately one million people would receive this money—some who are now receiving no benefits at all and some who now receive benefits but who would get more under this new arrangement. These suggestions are not by any means the solution to all the problems of the retirement test, however, and I am asking the Advisory Council on Social Security to give particular attention to this matter.

Contribution and Benefit Base

The contribution and benefit base—the annual earnings on which Social Security contributions are paid and that can be counted toward Social Security benefits—has been increased several times since the Social Security program began. The further increase I am recommending—from its present level of \$7800 to \$9000 beginning January 1, 1972—will produce approximately the same relationship between the base and general earnings levels as that of the early 1950s. This is important since the goal of Social Security is the replacement, in part, of lost earnings; if the base on which contributions and benefits are figured does not rise with earnings increases, then the benefits deteriorate. The future benefit increases that will result from the higher base I am recommending today would help to prevent such deterioration. These increases would, of course, be in addition to those which result from the 10% across-the-board increase in benefits that is intended to bring them into line with the cost of living.

Financing

I recommend an acceleration of the tax rate scheduled for hospital insurance to bring the hospital insurance trust fund into actuarial balance. I also propose to decelerate the rate schedule of the old-age, survivors and disability insurance trust funds in current law. These funds taken together have a long-range surplus of income over outgo, which will meet much of the cost. The combined rate, known as the "social security contribution," already scheduled by statute, will be decreased from 1971 through 1976. Thus, in 1971 the currently scheduled rate of 5.2% to be paid by employees would become 5.1%, and in 1973 the currently scheduled rate of 5.65% would become 5.5%. The actuarial integrity of the two funds will be maintained, and the ultimate tax rates will not be changed in the rate schedules which will be proposed.

The voluntary supplementary medical insurance (SMI) of title XVIII of the Social Security Act, often referred to as part B Medicare coverage, is not adequately financed with the current \$4 premium. Our preliminary studies indicate that there will have to be a substantial increase in the premium. The Secretary of Health, Education and Welfare will set the premium rate in December for the fiscal year beginning July 1970, as he is required to do by statute.

To meet the rising costs of health care in the United States, this Administration will soon forward a Health Cost Control proposal to the Congress. Other administrative measures are already being taken to hold down spiraling medical expenses.

In the coming months, this Administration will give careful study to ways in which we can further improve the Social Security program.

The program is an established and important American institution, a foundation on which millions are able to build a more comfortable life than would otherwise be possible—after their retirement or in the event of disability or death of the family earner.

The recommendations I propose today, which I urge the Congress to adopt, will move the cause of Social Security forward on a broad front.

We will bring benefit payments up to date.

We will make sure that benefit payments stay up to date, automatically tied to the cost of living.

We will begin making basic reforms in the system to remove inequities and bring a new standard of fairness in the treatment of all Americans in the system.

And we will lay the groundwork for further study and improvement of a system that has served the country well and must serve future generations more fairly and more responsively.

RICHARD NIXON.

THE WHITE HOUSE, *September 25, 1969.*

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The President's Proposals for
Welfare Reform and Social
Security Amendments, 1969,
Committee Print, Committee on
Ways and Means, U. S. House
of Representatives.



COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

THE PRESIDENT'S PROPOSALS
FOR
WELFARE REFORM
AND
SOCIAL SECURITY AMENDMENTS
1969

INCLUDING DRAFT BILLS, SUMMARIES, AND
OTHER MATERIAL TRANSMITTED BY
THE DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE



OCTOBER 1969

NOTE: This document has been printed for information purposes only so as to make it generally available. It has not been considered by the Committee on Ways and Means.

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CHARLES A. VANIK, Ohio

RICHARD H. FULTON, Tennessee

JACOB H. GILBERT, New York

OMAR BURLESON, Texas

JAMES C. CORMAN, California

WILLIAM J. GREEN, Pennsylvania

SAM M. GIBBONS, Florida

JOHN W. BYRNES, Wisconsin

JAMES B. UTT, California

JACKSON E. BETTS, Ohio

HERMAN T. SCHNEEBELI, Pennsylvania

HAROLD R. COLLIER, Illinois

JOEL T. BROYHILL, Virginia

BARBER B. CONABLE, Jr., New York

GEORGE BUSH, Texas

ROGERS C. B. MORTON, Maryland

CHARLES E. CHAMBERLAIN, Michigan

JOHN M. MARTIN, Jr., *Chief Counsel*

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MESSAGE ON SOCIAL SECURITY

THE WHITE HOUSE

To the Congress of the United States:

This Nation must not break faith with those Americans who have a right to expect that Social Security payments will protect them and their families.

The impact of an inflation now in its fourth year has undermined the value of every Social Security check and requires that we once again increase the benefits to help those among the most severely victimized by the rising cost of living.

I request that the Congress remedy the real losses to those who now receive Social Security benefits by increasing payments by 10 percent.

Beyond that step to set right today's inequity, I propose that the Congress make certain once and for all that the retired, the disabled and the dependent never again bear the brunt of inflation. *The way to prevent future unfairness is to attach the benefit schedule to the cost of living.*

This will instill new security in Social Security. This will provide peace of mind to those concerned with their retirement years, and to their dependents.

By acting to raise benefits now to meet the rise in the cost of living, we keep faith with today's recipients. By acting to make future benefit raises automatic with rises in the cost of living, we remove questions about future years; we do much to remove this system from biennial politics; and we make fair treatment of beneficiaries a matter of certainty rather than a matter of hope.

In the 34 years since the Social Security program was first established, it has become a central part of life for a growing number of Americans. Today approximately 25 million people are receiving cash payments from this source. Three-quarters of these are older Americans; the Social Security check generally represents the greater part of total income. Millions of younger people receive benefits under the disability or survivor provisions of Social Security.

Almost all Americans have a stake in the soundness of the Social Security system. Some 92 million workers are contributing to Social Security this year. About 80 percent of Americans of working age are protected by disability insurance and 95 percent of children and mothers have survivorship insurance protection. Because the Social Security program is an essential part of life for so many Americans, we must continually reexamine the program and be prepared to make improvements.

Aiding in this administration's review and evaluation is the Advisory Council on Social Security which the Secretary of Health, Education, and Welfare appointed in May. For example, I will look to this Council for recommendations in regard to working women; changing work patterns and the increased contributions of working

women to the system may make present law unfair to them. The recommendations of this Council and of other advisers, both within the Government and outside of it, will be important to our planning. As I indicated in my message to the Congress on April 14, improvement in the Social Security program is a major objective of this administration.

There are certain changes in the Social Security program, however, for which the need is so clear that they should be made without awaiting the findings of the Advisory Council. The purpose of this message is to recommend such changes.

I propose an across-the-board increase of 10 percent in social security benefits, effective with checks mailed in April 1970, to make up for increases in the cost of living.

I propose that future benefits in the social security system be automatically adjusted to account for increases in the cost of living.

I propose an increase from \$1,680 to \$1,800 in the amount beneficiaries can earn annually without reduction of their benefits, effective January 1, 1971.

I propose to eliminate the \$1-for-\$1 reduction in benefits for income earned in excess of \$2,880 a year and replace by a \$1 reduction in benefits for every \$2 earned, which now applies at earnings levels between \$1,680 and \$2,880, also effective January 1, 1971.

I propose to increase the contribution and benefit base from \$7,800 to \$9,000, beginning in 1972, to strengthen the system, to help keep future benefits to the individual related to the growth of his wages, and to meet part of the cost of the improved program. From then on, the base will automatically be adjusted to reflect wage increases.

I propose a series of additional reforms to insure more equitable treatment for widows, recipients above age 72, veterans, for persons disabled in childhood and for the dependent parents of disabled and retired workers.

I emphasize that the suggested changes are only first steps, and that further recommendations will come from our review process.

The social security system needs adjustment now so it will better serve people receiving benefits today, and those corrections are recommended in this message. The system is also in need of long-range reform, to make it better serve those who contribute now for benefits in future years, and that will be the subject of later recommendations.

THE BENEFIT INCREASE

With the increase of 10 percent, the average family benefit for an aged couple, both receiving benefits, would rise from \$170 to \$188 a month. Further indication of the impact of a 10 percent increase on monthly benefits can be seen in the following table:

	Present minimum	New minimum	Present maximum	New maximum
Single person (a man retiring at age 65 in 1970).....	\$55.00	\$61.00	\$165.00	\$181.50
Married couple (husband retiring at age 65 in 1970).....	82.50	91.50	247.50	272.30

The proposed benefit increases will raise the income of more than 25 million persons who will be on the Social Security rolls in April 1970.

Total budget outlays for the first full calendar year in which the increase is effective will be approximately \$3 billion.

AUTOMATIC ADJUSTMENTS

Benefits will be adjusted automatically to reflect increases in the cost of living. The uncertainty of adjustment under present laws and the delay often encountered when the needs are already apparent is unnecessarily harsh to those who must depend on Social Security benefits to live.

Benefits that automatically increase with rising living costs can be funded without increasing Social Security tax rates so long as the amount of earnings subject to tax reflects the rising level of wages. Therefore, I propose that the wage base be automatically adjusted so that it corresponds to increases in earnings levels.

These automatic adjustments are interrelated and should be enacted as a package. Taken together they will depoliticize, to a certain extent, the Social Security system and give a greater stability to what has become a cornerstone of our society's social insurance system.

REFORMING THE SYSTEM

I propose a series of reforms in present Social Security law to achieve new standards of fairness. These would provide:

1. *An increase in benefits to a widow who begins receiving her benefit at age 65 or later.* The benefit would increase the current 82½ percent of her husband's benefit to a full 100 percent. This increased benefit to widows would fulfill a pledge I made a year ago. It would provide an average increase of \$17 a month to almost 3 million widows.

2. *Noncontributory earnings credits of about \$100 a month for military service* from January 1957 to December 1967. During that period, individuals in military service were covered under Social Security but credit was not then given for wages in kind—room and board, etc. A law passed in 1967 corrected this for the future, but the men who served from 1957 (when coverage began for servicemen) to 1967 should not be overlooked.

3. *Benefits for the aged parents of retired and disabled workers.* Under present law, benefits are payable only to the dependent parents of a worker who has died; we would extend this to parents of workers who are disabled or who retire.

4. *Child's insurance benefits for life* if a child becomes permanently disabled before age 22. Under present law, a person must have become disabled before age 18 to qualify for these benefits. The proposal would be consistent with the payment of child's benefit to age 22 so long as the child is in school.

5. *Benefits in full paid to persons over 72, regardless of the amount of his earnings in the year he attains that age.*—Under present law, he is bound by often confusing tests which may limit his exemption.

6. *A fairer means of determining benefits payable on a man's earnings record.*—At present, men who retire at age 62 must compute their average earnings through 3 years of no earnings up to age 65, thus lowering the retirement benefit excessively. Under this proposal, only the years up to age 62 would be counted, just as is now done for women, and 3 higher-earning years could be substituted for low-earning years.

CHANGES IN THE RETIREMENT TEST

A feature of the present social security law that has drawn much criticism is the so-called "retirement test," a provision which limits the amount that a beneficiary can earn and still receive full benefits. I have been much concerned about this provision, particularly about its effects on incentives to work. The present retirement test actually penalizes social security beneficiaries for doing additional work or taking a job at higher pay. This is wrong.

In my view, many older people should be encouraged to work. Not only are they provided with added income, but the country retains the benefit of their skills and wisdom; they, in turn, have the feeling of usefulness and participation which employment can provide.

This is why I am recommending changes in the retirement test. Raising the amount of money a person can earn in a year without affecting his social security payments—from the present \$1,680 to \$1,800—is an important first step. But under the approach used in the present retirement test, people who earned more than the exempt amount of \$1,680, plus \$1,200, would continue to have \$1 in social security benefits withheld for every \$1 they received in earnings. A necessary second step is to eliminate from present law the requirement that when earnings reach \$1,200 above the exempt amount, social security benefits will be reduced by a full dollar for every dollar of added earnings until all his benefits are withheld; in effect, we impose a tax of more than 100 percent on these earnings.

To avoid this, I would eliminate this \$1 reduction for each \$1 earned and replace it with the same \$1 reduction for each \$2 earned above \$3,000. This change will reduce a disincentive to increased employment that arises under the retirement test in its present form.

The amount a retired person can earn and still receive his benefits should also increase automatically with the earnings level. It is sound policy to keep the exempt amount related to changes in the general level of earnings.

These alterations in the retirement test would result in added benefit payments of some \$300 million in the first full calendar year. Approximately 1 million people would receive this money—some who are now receiving no benefits at all and some who now receive benefits but who would get more under this new arrangement. These suggestions are not by any means the solution to all the problems of the retirement test, however, and I am asking the advisory council on social security to give particular attention to this matter.

CONTRIBUTION AND BENEFIT BASE

The contribution and benefit base—the annual earnings on which social security contributions are paid and that can be counted toward social security benefits—has been increased several times since the social security program began. The further increase I am recommending—from its present level of \$7,800 to \$9,000 beginning January 1, 1972—will produce approximately the same relationship between the base and general earnings levels as that of the early 1950's. This is important since the goal of social security is the replacement, in part,

of lost earnings; if the base on which contributions and benefits are figured does not rise with earnings increases, then the benefits deteriorate. The future benefit increases that will result from the higher base I am recommending today would help to prevent such deterioration. These increases would, of course, be in addition to those which result from the 10-percent across-the-board increase in benefits that is intended to bring them into line with the cost of living.

FINANCING

I recommend an acceleration of the tax rate scheduled for hospital insurance to bring the hospital insurance trust fund into actuarial balance. I also propose to decelerate the rate schedule of the old-age, survivors, and disability insurance trust funds in current law. These funds, taken together, have a long-range surplus of income over outgo, which will meet much of the cost. The combined rate, known as the social security contribution, already scheduled by statute, will be decreased from 1971 through 1976. Thus, in 1971 the current scheduled rate of 5.2 percent to be paid by employees would become 5.1 percent, and in 1973 the current scheduled rate of 5.65 percent would become 5.1 percent. The actuarial integrity of the two funds will be maintained, and the ultimate tax rates will not be changed in the rate schedules which will be proposed.

The voluntary supplementary medical insurance (SMI) of title XVIII of the Social Security Act, often referred to as part B medicare coverage, is not adequately financed with the current \$4 premium. Our preliminary studies indicate that there will have to be a substantial increase in the premium. The Secretary of Health, Education, and Welfare will set the premium rate in December for the fiscal year beginning July 1970, as he is required to do by statute.

To meet the rising costs of health care in the United States, this administration will soon forward a health cost control proposal to the Congress. Other administrative measures are already being taken to hold down spiraling medical expenses.

In the coming months, this administration will give careful study to ways in which we can further improve the social security program. The program is an established and important American institution, a foundation on which millions are able to build a more comfortable life than would otherwise be possible—after their retirement or in the event of disability or death of the family earner.

The recommendations I propose today, which I urge the Congress to adopt, will move the cause of social security forward on a broad front.

We will bring benefit payments up to date.

We will make sure that benefit payments stay up to date, automatically tied to the cost of living.

We will begin making basic reforms in the system to remove inequities and bring a new standard of fairness in the treatment of all Americans in the system.

And we will lay the groundwork for further study and improvement of a system that has served the country well and must serve future generations more fairly and more responsively.

RICHARD NIXON.

THE WHITE HOUSE,
September 25, 1969.

LETTER OF TRANSMITTAL

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,

Washington, D.C., September 30, c 1969.

HON. JOHN W. McCORMACK,
*Speaker of the House of
Representatives,
Washington, D.C.*

HON. SPIRO T. AGNEW,
*President of the Senate,
Washington, D.C.*

DEAR MR. PRESIDENT:

DEAR MR. SPEAKER:

I am transmitting with this letter draft legislation to amend the social security program. Also enclosed are a summary and a section-by-section analysis of the draft bill. This draft is designed to carry out the recommendations made in the President's message on social security of September 25, 1969.

The proposed legislation calls for an across-the-board increase of 10 percent in social security payments, effective March 1970, to make up for increases in the cost of living since Congress last raised the benefits. The legislation also provides for subsequent automatic increases in benefits based upon increases in the cost of living. Other provisions would substantially revise the retirement test, increase the earnings base to \$9,000 per year and increase it automatically thereafter, increase the benefits payable to widows and dependent widowers who begin drawing benefits at age 65 or later from 82½ percent of the deceased worker's benefit to 100 percent of that amount, make aged dependent parents of retired and disabled workers eligible for benefits and liberalize the provisions for determining the insured status and benefit computation for men.

We urge that early and favorable consideration be given to the enactment of this bill, and we would appreciate your forwarding the proposed legislation to the appropriate committee.

The Bureau of the Budget advises the enactment of this bill would be in accord with the program of the President.

Sincerely,

ROBERT H. FINCH, *Secretary.*

SUMMARY OF THE PROPOSED SOCIAL SECURITY AMENDMENTS OF 1969

Benefit increase

The bill provides for a 10-percent across-the-board increase in cash social security benefits, effective March 1970 and payable in April 1970.

Under the proposal, an automatic increase in benefits is provided in the event of future increases in the cost of living. Whenever the Consumer Price Index prepared by the Department of Labor rises by at least 3 percent, benefits will be increased by that percent. These automatic increases would not be made more often than once a year.

Certain people age 72 and over would receive a 10-percent increase in the special amount that is paid them. These individuals are not now insured under the regular social security cash benefits program. The increase would be effective for March 1970.

The bill changes the present method of determining eligibility for benefits and benefit amounts based on a man's earnings record, making it similar to that now in use for women.

Average monthly earnings for a man—and it is on this average that the monthly benefits are based—are now determined over a period equal to the number of years up to age 65, while for women they are figured over a period equal to the number of years up to age 62. The result of this difference is generally that a man's retirement benefit amount is lower than that of a woman with exactly the same earnings record. Under the bill, this difference would be eliminated. As a result, the treatment of men and women workers under the benefit provisions would be the same, and the retirement benefits payable to men, the benefits payable to their wives, and the benefits payable to survivors of men who live beyond age 62 would be increased.

Widows and widowers

The bill provides benefits for a widow at age 65 equal to 100 percent of the amount her husband would have received at age 65, rather than 82½ percent as under present law. Benefits for widows aged 62–64 would be graded down according to the age of the widow at the time she first gets benefits; a widow coming on the rolls at age 62 would receive 82½ percent of the husband's benefit, as she does under present law. This provision would be effective with benefits for January 1971.

Contribution and benefit base

The bill provides for an increase in the contribution and benefit base (that is, the amount of annual earnings that may be counted for social security purposes) from the present \$7,800 per year to \$9,000 per year. This provision becomes effective on January 1, 1972.

The bill provides also for automatic adjustment of the contribution and benefit base to future increases in wage levels, beginning with 1974. The adjustments of the base could not be made more frequently than every second year.

Retirement test

Under this legislation, there would be four significant changes in the social security retirement test, liberalizing that test as follows: Under present law, full social security benefits are payable to a beneficiary whose earnings do not exceed \$1,680 for a year. If he has earnings of more than \$1,680, \$1 in benefits is withheld for each \$2 between \$1,680 and \$2,880, but there is a dollar-for-dollar reduction for earnings above \$2,880. (However, benefits are not withheld for a month if wages are not more than \$140 and substantial services are not rendered in self-employment.)

The proposal is to :

(a) Increase the annual exempt amount from \$1,680 to \$1,800 (and the monthly earnings test from \$140 to \$150) ;

(b) Provide for reduction in benefits of \$1 for each \$2 of *all* earnings in excess of the exempt amount of \$1,800 ;

(c) Provide for automatic upward adjustment of the annual exempt amount (and the monthly test) in relation to future increases in earnings levels ;

(d) Provide that in the year a beneficiary reaches age 72 earnings beginning with the month he attains age 72 would be disregarded in computing the amount of annual earnings for retirement test purposes. The annual exempt amount and the \$1-for-\$2 adjustment would apply to his earnings in the year up to the month in which he attains age 72. (Under present law, earnings after the month a beneficiary attains age 72, but in the same year, must be included in determining whether any benefits are to be withheld for months before attainment of age 72.)

The changes in the retirement test would become effective generally on January 1, 1971.

Parent's benefits

The bill provides benefits for the dependent aged parents of retired or disabled workers. Under present law, benefits are provided only for the dependent parents of deceased workers. The benefit amounts for the parent of a living worker would be equal to 50 percent of the worker's primary insurance amount (like a husband's or wife's benefit under present law), actuarially reduced if taken at age 62-65. The benefit amount for parents of deceased workers would continue to be 82½ percent of the primary insurance amount, or 75 percent of that amount, depending on whether one or more parents were entitled to benefits.

Childhood disability benefits

The bill provides childhood disability benefits for a disabled son or daughter of an insured deceased, disabled, or retired worker if the son or daughter became totally disabled after age 18 and before reaching age 22. Under present law, a person must have become totally disabled before age 18 to qualify for childhood disability benefits.

Military service credits

The bill provides noncontributory wage credits (\$100 for each month of military service) for individuals who served on active duty in the military services from January 1957 through December 1967. These credits, reflecting wages-in-kind received by servicemen, would be in

addition to credits for service basic pay, which has been subject to contributory coverage since January 1, 1957. Present law provides similar \$100-a-month noncontributory credits for military service after 1967, and \$160-a-month noncontributory credits for service from September 1940 through December 1956.

Financing

Under the most recent of the periodic actuarial reevaluations of the cash benefits part of the social security program, income over the long-range future exceeds long-range outgo by 1.16 percent of taxable payroll. The excess of long-range income over outgo as shown in the last preceding evaluation was 0.53 percent of taxable payroll. The larger excess shown in the most recent estimates results from taking into account 1969 (as against 1968) earnings levels, the higher interest rates now being earned by the trust funds, and increased labor-force participation of both men and women. Preliminary results of the latest reevaluation of the hospital insurance program indicate that the long-range income of the program will be less than long-range outgo by 0.77 percent of taxable payroll.

A large part of the cost of the proposed improvement in the cash benefits program will be covered by the long-range excess of income over outgo in that part of the social security program. The proposed increase in the contribution and benefit base to \$9,000 will also help to meet part of the cost of the improvements, since income from the increase in the base will exceed the cost of the additional benefits that will be paid on earnings above the present \$7,800 ceiling.

Automatic increases in the contribution and benefit base in line with increases in wage levels will provide additional income sufficient to meet fully the cost of the additional benefit payments that will result from automatic adjustment of benefits in line with increases in the cost of living and from automatic adjustment of the retirement test. In summary, the cash benefits part of the social security program, with the recommended improvements, will be adequately financed; and, in fact, the rate increases scheduled in present law for the cash benefits part of the program can be put into effect considerably later than scheduled in present law.

The contribution rate for cash benefits, now scheduled to rise to 5 percent each for employees and employers in 1973 and thereafter, would not reach 5 percent under the bill until 1987. The delay in the scheduled increases in the contribution rates for cash benefits will prevent unnecessary, large-scale increases in the cash benefits trust funds.

The contribution rates for hospital insurance would rise under the bill from 0.6 percent each for employees and employers to 0.9 percent each in 1971 and thereafter, as against rising to the 0.9 level in 1987 and thereafter as under present law. The revision in the contribution rates scheduled for hospital insurance and the increases in the contribution and benefit base to \$9,000 in 1972, with automatic adjustment thereafter, will leave the hospital insurance trust fund with an actuarial balance of 0.06 percent of payroll under the bill, as against a minus balance of 0.77 percent under present law.

Under the proposed revisions in the contribution rate schedules, the combined rates for cash benefits and hospital insurance will be lower than in present law for 1971 through 1976 and will be the same as in present law for 1977 and thereafter.

The contribution rate schedules under present law and the bill are shown in the following table.

CONTRIBUTION RATES FOR EMPLOYEES AND EMPLOYERS, EACH, UNDER PRESENT LAW AND UNDER PROPOSAL
[In percent]

	Present law			Proposal		
	Cash benefits	Hospital insurance	Total	Cash benefits	Hospital insurance	Total
Year:						
1970.....	4.20	0.60	4.80	4.2	0.60	4.80
1971-72.....	4.60	.60	5.20	4.2	.90	5.10
1973-74.....	5.00	.65	5.65	4.2	.90	5.10
1975.....	5.00	.65	5.65	4.6	.90	5.50
1976.....	5.00	.70	5.70	4.6	.90	5.50
1977-79.....	5.00	.70	5.70	4.8	.90	5.70
1980-86.....	5.00	.80	5.80	4.9	.90	5.80
1987 and after.....	5.00	.90	5.90	5.0	.90	5.90

CONTRIBUTION RATES FOR THE SELF-EMPLOYED UNDER PRESENT LAW AND UNDER PROPOSAL

[In percent]

	Present law			Proposal		
	Cash benefits	Hospital insurance	Total	Cash benefits	Hospital insurance	Total
Year:						
1970.....	6.30	0.60	6.90	6.30	0.60	6.90
1971-72.....	6.90	.60	7.50	6.30	.90	7.20
1973-74.....	7.00	.65	7.65	6.30	.90	7.20
1975.....	7.00	.65	7.65	6.90	.90	7.80
1976.....	7.00	.70	7.70	6.90	.90	7.80
1977-79.....	7.00	.70	7.70	7.00	.90	7.90
1980-86.....	7.00	.80	7.80	7.00	.90	7.90
1987 and after.....	7.00	.90	7.90	7.00	.90	7.90

SECTION-BY-SECTION ANALYSIS OF THE PROPOSED SOCIAL SECURITY AMENDMENTS OF 1969

Section 1. Short title

This section specifies that the bill may be cited as the "Social Security Amendments of 1969".

Section 2. Increase in old-age, survivors, and disability insurance benefits

This section provides a general benefit increase for current and future beneficiaries. Benefits are increased across the board by 10 percent, with a minimum benefit of \$61 instead of the present \$55. The maximum retirement benefit for a worker alone is increased from the present \$218 to \$250. Maximum family benefits payable for the future will range from \$91.50 to \$480 a month compared with the present range of \$82.50 to \$434.40. The general benefit increase becomes effective with benefits for March 1970 payable in April.

Section 3. Increase in special payments for certain people age 72 and over

Under this section there will be a 10-percent increase in the amounts of benefits payable to certain people age 72 and over who either have not worked at all under social security or have not worked in covered employment long enough to meet the regular insured status requirements. The increased benefits will be \$44 for an individual and \$66 for a couple, instead of \$40 and \$60 as under present law. This increase becomes effective with benefits for March 1970.

Section 4. Automatic adjustment of benefits

This section provides for automatic cost-of-living increases in social security cash benefits. The automatic increases in benefits would not be made more often than once a year.

The calculation of the increase in the cost of living would be based on the Consumer Price Index prepared by the Department of Labor. Under the first such calculation, the monthly average of the Consumer Price Index for the third calendar quarter of 1970 would be compared with the monthly average of the Consumer Price Index for the third calendar quarter of 1969. If the monthly average of the Consumer Price Index for the third calendar quarter of 1970 exceeded the monthly average of the Consumer Price Index for the third calendar quarter of 1969 by at least 3 percent, monthly benefits for people who are then and who later become entitled to benefits would be increased, effective for benefits paid for January 1971, by the percentage increase (rounded to the nearest one-tenth of 1 percent) by which the Consumer Price Index had increased. (Lump-sum death payments would be increased for deaths occurring after November 1971.)

A similar calculation would be made in each subsequent calendar year, with the monthly average of the Consumer Price Index for the third quarter of that year being compared with the average of the

Consumer Price Index for the third quarter of the most recent year that necessitated a cost-of-living increase.

The cost-of-living increases provided by this section would apply not only to individual benefits but also to the maximum family benefit amounts.

Section 5. Liberalization of the earnings test for retirement purposes

This section makes four changes in the social security retirement test. Under present law, full social security benefits are payable to a beneficiary under age 72 whose earnings do not exceed \$1,680 for a year. If he has earnings of more than \$1,680, \$1 in benefits is withheld for each \$2 between \$1,680 and \$2,880, but there is a dollar-for-dollar reduction for earnings above \$2,880. (However, benefits are not withheld for a month if in that month the beneficiary's wages are not more than \$140 or substantial services are not rendered in self-employment.) The bill will:

(a) Increase the annual exempt amount of earnings from \$1,680 to \$1,800 (and the monthly earnings test from \$140 to \$150);

(b) Provide for reduction in benefits of \$1 for each \$2 of all earnings in excess of the exempt amount of \$1,800;

(c) Provide for automatic upward adjustment of the annual exempt amount (and the monthly earnings test) in relation to future increases in average earnings levels;

(d) Provide that in the year a beneficiary reaches age 72 earnings beginning with the month he attains age 72 would not be considered in computing the amount of annual earnings exempt for retirement test purposes. The annual exempt amount and the \$1 for \$2 adjustment would apply to his earnings in the year up to the month in which he attains age 72. (Under present law, earnings after the month a beneficiary attains age 72, but in the same year, must be included in determining whether any of an individual's benefits are to be withheld for months in the year before he attained age 72.)

The changes in the retirement test would become effective generally on January 1, 1971.

Section 6. Increase in earnings counted for benefit and contribution purposes

This section provides for an increase in the contribution and benefit base—the maximum amount of annual earnings that are subject to social security contributions and creditable toward social security benefits. The base would be increased from the present \$7,800 to \$9,000, effective on January 1, 1972.

Section 7. Automatic adjustment of the contribution and benefit base

This section provides for automatic adjustments of the contribution and benefit base to future increases in average wage levels beginning with 1974. On or before October 1, 1972, and of each even-numbered year thereafter, the Secretary of Health, Education, and Welfare will determine and publish in the Federal Register the contribution and benefit base for the 2 calendar years beginning January 1 of the next even-numbered year. The base for a particular year is to be the product of \$9,000 and the ratio of (A) the average covered wages of all persons for whom taxable wages were reported for the first calendar quarter

of the year in which the determination is being made to (B) the average covered wages of all persons for whom taxable wages were reported for the first calendar quarter of 1971. That product, if not a multiple of \$600, is to be rounded to the nearest multiple of \$600. If the base so determined is smaller than the base already in effect, the base that is in effect will continue in effect for 2 more years. The section also provides formula for determining benefit amounts and maximum family benefits for average monthly earnings above \$750 (\$9,000 a year).

Section 8. Changes in contribution rate

Under this section, the contribution rates for both the cash benefits and the hospital insurance parts of the program will be revised. The contribution rate schedules under present law and under the bill are shown in the following tables.

CONTRIBUTION RATES FOR EMPLOYEES AND EMPLOYERS, EACH, UNDER PRESENT LAW
AND UNDER THE BILL

[In percent]

	Present law			Proposal		
	Cash benefits	Hospital insurance	Total	Cash benefits	Hospital insurance	Total
Year:						
1970.....	4.20	0.60	4.80	4.20	0.60	4.80
1971-72.....	4.60	.60	5.20	4.20	.90	5.10
1973-74.....	5.00	.65	5.65	4.20	.90	5.10
1975.....	5.00	.65	5.65	4.60	.90	5.50
1976.....	5.00	.70	5.70	4.60	.90	5.50
1977-79.....	5.00	.70	5.70	4.80	.90	5.70
1980-86.....	5.00	.80	5.80	4.90	.90	5.80
1987 and after.....	5.00	.90	5.90	5.00	.90	5.90

CONTRIBUTION RATES FOR THE SELF-EMPLOYED UNDER PRESENT LAW AND UNDER THE BILL

[In percent]

	Present law			Proposal		
	Cash benefits	Hospital insurance	Total	Cash benefits	Hospital insurance	Total
Year:						
1970.....	6.30	0.60	6.90	6.30	0.60	6.90
1971-72.....	6.90	.60	7.50	6.30	.90	7.20
1973-74.....	7.00	.65	7.65	6.30	.90	7.20
1975.....	7.00	.65	7.65	6.90	.90	7.80
1976.....	7.00	.70	7.70	6.90	.90	7.80
1977-79.....	7.00	.70	7.70	7.00	.90	7.90
1980-86.....	7.00	.80	7.80	7.00	.90	7.90
1987 and after.....	7.00	.90	7.90	7.00	.90	7.90

Section 9. Age 62 computation point for men

This section provides that the ending point of the period that is used to determine insured status for men and the ending point of the period that is used to determine the number of years over which a man's average monthly earnings must be calculated, will be the beginning of the year in which he reaches age 62, instead of age 65 as is provided under present law. The ending point for men would thus be the same as it is for women under present law. One effect of the proposed change is that a man's average monthly earnings in retirement cases could be figured over 3 fewer years than they are under present

law, resulting in most cases in higher average monthly earnings for him and thus higher benefits for him and his family.

The change is effective with benefits for January 1971, and will be applicable both to people already on the benefit rolls and to those who will come on in the future.

Section 10. Entitlement to child's insurance benefits based on disability which began between 18 and 22

This section provides childhood disability benefits for a son or daughter of an insured deceased, disabled, or retired worker if the son or daughter became totally disabled after age 18 and before reaching age 22, and continues to be totally disabled. Under present law, a person must have been totally disabled since before age 18 to qualify for childhood disability benefits. This change would be applicable to monthly benefits for months after December 1970.

Section 11. Disability insurance trust fund

This section would increase the percentage of taxable wages appropriated to the disability insurance trust fund—now 0.95 of 1 percent of payroll—to 1.05 percent, and would increase the percentage of income from self-employment appropriated to the disability insurance trust fund—now 0.7125 of 1 percent—to 0.7875 of 1 percent, effective for 1970.

Section 12. Wage credits for members of the uniformed services

This section provides noncontributory earnings credits of \$300 for each calendar quarter of military service after December 1956 and before January 1968. These credits, designed to give social security credit for wages in kind received by servicemen, would supplement credit for military service basic pay, which has been subject to contributory social security coverage since January 1, 1957. Present law provides similar noncontributory wage credits for military service after 1967 and \$160-a-month noncontributory wage credits for service from September 1940 through December 1956. The new wage credits, like the previously provided noncontributory wage credits, would be financed from general revenues. The new credits would be used in computing monthly benefits for months after December 1970 and lump-sum death payments in the case of deaths after 1970.

Section 13. Parent's insurance benefits

This section would provide for the payment of benefits to aged dependent parents of retired and disabled workers, effective for January 1971. Such benefits are now provided for dependent parents of deceased workers. The benefits for the dependent parent of a retired or disabled individual would be equal to 50 percent of that individual's benefit, except that it would be actuarially reduced if taken before age 65. The benefit for a parent of a deceased worker would continue as in present law to be 82½ percent of the worker's benefit if there is one parent and 75 percent each if there are two.

Section 14. Increase in widow's insurance benefits

This section increases benefits for widows, and widowers, who came on the benefit rolls, and those who come on in the future, after age 62. For a widow becoming entitled to benefits at or after age 65, the benefit would be equal to 100 percent of the amount of her husband's benefit

at age 65, rather than $82\frac{1}{2}$ percent as under present law. For widows coming on the rolls between age 62 and 65, benefit amounts would range from the $82\frac{1}{2}$ percent payable at age 62 under present law and under the bill to the 100 percent payable at age 65 under the bill. For example, the benefit amount for a widow becoming entitled to widow's benefits at age 63 would be $88\frac{1}{3}$ percent of her husband's age 65 benefit; for a widow becoming entitled at age 64, the amount would be equal to $94\frac{1}{6}$ percent of her husband's benefit. The increase in widow's benefits would become effective with benefits payable for January 1971.

PROPOSED SOCIAL SECURITY AMENDMENTS OF 1969

A BILL To amend the Social Security Act to provide an increase in benefits under the old-age, survivors, and disability insurance program, provide for automatic benefit increases thereafter in the event of future increases in the cost of living, provide for future automatic increases in the earnings and contribution base, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Social Security Amendments of 1969".

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- Sec. 1. Short Title.
- Sec. 2. Increase in OASDI Benefits.
- Sec. 3. Increase in Benefits for Certain Individuals Age 72 and Over.
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- Sec. 5. Liberalization of Earnings Test.
- Sec. 6. Increase of Earnings Counted for Benefit and Tax Purposes.
- Sec. 7. Automatic Adjustment of Earnings Base.
- Sec. 8. Changes in Tax Schedules.
- Sec. 9. Age-62 Computation Point for Men.
- Sec. 10. Entitlement to Child's Insurance Benefits Based on Disability Which Began Between 18 and 22.
- Sec. 11. Allocation to Disability Insurance Trust Fund.
- Sec. 12. Wage Credits for Members of the Uniformed Services.
- Sec. 13. Parent's Insurance Benefits in Case of Retired or Disabled Worker.
- Sec. 14. Increase in Widow's and Widower's Insurance Benefits.

INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

SEC. 2. (a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 act, as modified)		II (Primary insurance amount under 1967 act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
-----	\$16.20	\$55.40 or less	-----	\$76	\$61.00	\$91.50
\$16.21-----	16.84	56.50	\$77	78	62.20	93.30
\$16.85-----	17.60	57.70	79	80	63.50	95.30
\$17.61-----	18.40	58.80	81	81	64.70	97.10
\$18.41-----	19.24	59.90	82	83	65.90	98.90
\$19.25-----	20.00	61.10	84	85	67.30	101.00
\$20.01-----	20.64	62.20	86	87	68.50	102.80
\$20.65-----	21.28	63.30	88	89	69.70	104.60
\$21.29-----	21.88	64.50	90	90	71.00	106.50
\$21.89-----	22.28	65.60	91	92	72.20	108.30
\$22.29-----	22.68	66.70	93	94	73.40	110.10
\$22.69-----	23.08	67.80	95	96	74.60	111.90
\$23.09-----	23.44	69.00	97	97	75.90	113.90
\$23.45-----	23.76	70.20	98	99	77.30	116.00

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I		II	III		IV	V
(Primary insurance benefit under 1939 act, as modified)		(Primary insurance amount under 1967 act)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
\$23.77	24.20	71.50	100	101	78.70	118.10
\$24.21	24.60	72.60	102	102	79.90	119.90
\$25.61	25.00	73.80	103	104	81.20	121.80
\$25.01	25.48	75.10	105	106	82.70	124.10
\$25.49	25.92	76.30	107	107	84.00	126.00
\$25.93	26.40	77.50	108	109	85.30	128.00
\$26.41	26.94	78.70	110	113	86.60	129.90
\$26.95	27.46	79.90	114	118	87.90	131.90
\$27.47	28.00	81.10	119	122	89.30	134.00
\$28.01	28.68	82.30	123	127	90.60	135.90
\$28.69	29.25	83.60	128	132	92.00	138.00
\$29.26	29.68	84.70	133	136	93.20	139.80
\$29.69	30.36	85.90	137	141	94.50	141.80
\$30.37	30.92	87.20	142	146	96.00	144.00
\$30.93	31.36	88.40	147	150	97.30	146.00
\$31.37	32.00	89.50	151	155	98.50	147.80
\$32.01	32.60	90.80	156	160	99.90	149.90
\$32.61	33.20	92.00	161	164	101.20	151.80
\$33.21	33.88	93.20	165	169	102.60	153.90
\$33.89	34.50	94.40	170	174	103.90	155.90
\$34.51	35.00	95.60	175	178	105.20	157.80
\$35.01	35.80	96.80	179	183	106.50	159.80
\$35.81	36.40	98.00	184	188	107.80	161.70
\$36.41	37.08	99.30	189	193	109.30	164.00
\$37.09	37.60	100.50	194	197	110.60	165.90
\$37.61	38.20	101.60	198	202	111.80	167.70
\$38.21	39.12	102.90	203	207	113.20	169.80
\$39.13	39.68	104.10	208	211	114.60	171.90
\$39.69	40.33	105.20	212	216	115.80	173.70
\$40.34	41.12	106.50	217	221	117.20	176.80
\$41.13	41.76	107.70	222	225	118.50	180.00
\$41.77	42.44	108.90	226	230	119.80	184.00
\$42.45	43.20	110.10	231	235	121.20	188.00
\$43.21	43.76	111.40	236	239	122.60	191.20
\$43.77	44.44	112.60	240	244	123.90	195.20
\$44.45	44.88	113.70	245	249	125.10	199.20
\$44.89	45.60	115.00	250	253	126.50	202.40
		116.20	254	258	127.90	206.40
		117.30	259	263	129.10	210.40
		118.60	264	267	130.50	213.60
		119.80	268	272	131.80	217.60
		121.00	273	277	133.10	221.60
		122.20	278	281	134.50	224.80
		123.40	282	286	135.80	228.80
		124.70	287	291	137.20	232.80
		125.80	292	295	138.40	236.00
		127.10	296	300	139.90	240.00
		128.30	301	305	141.20	244.00
		129.40	306	309	142.40	247.20
		130.70	310	314	143.80	251.20
		131.90	315	319	145.10	255.20
		133.00	320	323	146.30	258.40
		134.30	324	328	147.80	262.40
		135.50	329	333	149.10	266.40
		136.80	334	337	150.50	269.60
		137.90	338	342	151.70	273.60
		139.10	343	347	153.10	277.60
		140.40	348	351	154.50	280.80
		141.50	352	356	155.70	284.80
		142.80	357	361	157.10	288.80
		144.00	362	365	158.40	292.00
		145.10	366	370	159.70	296.00
		146.40	371	375	161.10	300.00
		147.60	376	379	162.40	303.20
		148.90	380	384	163.80	307.20
		150.00	385	389	165.00	311.20
		151.20	390	393	166.40	314.40
		152.50	394	398	167.80	318.40
		153.60	399	403	169.00	322.40
		154.90	404	407	170.40	325.60

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I		II	III		IV	V
(Primary insurance benefit under 1939 act, as modified)		(Primary insurance amount under 1967 act)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		156.00	408	412	171.60	329.60
		157.10	413	417	172.90	333.60
		158.20	418	421	174.10	336.80
		159.40	422	426	175.40	340.80
		160.50	427	431	176.60	344.80
		161.60	432	436	177.80	348.80
		162.80	437	440	179.10	352.00
		163.90	441	445	180.30	356.00
		165.00	446	450	181.50	360.00
		166.20	451	454	182.90	361.60
		167.30	455	459	184.10	363.60
		168.40	460	464	185.30	365.60
		169.50	465	468	186.50	367.20
		170.70	469	473	187.80	369.20
		171.80	474	478	189.00	371.20
		172.90	479	482	190.20	372.80
		174.10	483	487	191.60	374.80
		175.20	488	492	192.80	376.80
		176.30	493	496	194.00	378.40
		177.50	497	501	195.30	380.40
		178.60	502	506	196.50	382.40
		179.70	507	510	197.70	384.00
		180.80	511	515	198.90	386.00
		182.00	516	520	200.20	388.00
		183.10	521	524	201.50	389.60
		184.20	525	529	202.70	391.60
		185.40	530	534	204.00	393.60
		186.50	535	538	205.20	395.20
		187.60	539	543	206.40	397.20
		188.80	544	548	207.70	399.20
		189.90	549	553	208.90	401.20
		191.00	554	556	210.10	402.40
		192.00	557	560	211.20	404.00
		193.00	561	563	212.30	405.20
		194.00	564	567	213.40	406.80
		195.00	568	570	214.50	408.00
		196.00	571	574	215.60	409.60
		197.00	575	577	216.70	410.80
		198.00	578	581	217.80	412.40
		199.00	582	584	218.90	413.60
		200.00	585	588	220.00	415.20
		201.00	589	591	221.10	416.40
		202.00	592	595	222.20	418.00
		203.00	596	598	223.30	419.20
		204.00	599	602	224.40	420.80
		205.00	603	605	225.50	422.00
		206.00	606	609	226.60	423.60
		207.00	610	612	227.70	424.80
		208.00	613	616	228.80	426.40
		209.00	617	620	229.90	428.00
		210.00	621	623	231.00	429.20
		211.00	624	627	232.10	430.80
		212.00	628	630	233.20	432.00
		213.00	631	634	234.30	433.60
		214.00	635	637	235.40	434.80
		215.00	638	641	236.50	436.40
		216.00	642	644	237.60	437.60
		217.00	645	648	238.70	439.20
		218.00	649	656	239.80	442.40
			657	666	241.00	446.40
			667	676	242.00	450.40
			677	685	243.00	454.00
			686	695	244.00	458.00
			696	705	245.00	462.00
			706	715	246.00	466.00
			716	725	247.00	470.00
			726	734	248.00	473.60
			735	744	249.00	477.60
			745	750	250.00	480.00

(b) Section 203(a) of such Act is amended by striking out paragraph (2) and inserting in lieu thereof the following:

“(2) when two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for March 1970 on the basis of the wages and self-employment income of such insured individual and at least one such person was so entitled for February 1970 on the basis of such wages and self-employment income, such total of benefits for March 1970 or any subsequent month shall not be reduced to less than the larger of—

“(A) the amount determined under this subsection without regard to this paragraph, or

“(B) an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsection (b), (c), and (d) of this section), as in effect prior to March 1970, for each such person for such month, by 110 percent and raising each such increased amount, if it is not a multiple of \$0.10, to the next higher multiple of \$0.10;

but in any such case (i) paragraph (1) of this subsection shall be applied to such total of benefits after the application of subparagraph (B), and (ii) if section 2202(k)(2)(A) was applicable in the case of any such benefits for March 1970, and ceases to apply after such months, the provisions of subparagraph (B) shall be applied, for and after the month in which section 202(k)(2)(A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for March 1970, or”.

(c) Section 215(b)(4) of such Act is amended by striking out “January 1968” each time it appears and inserting in lieu thereof “February 1970”.

(d) Section 215(c) of such Act is amended to read as follows:

“Primary Insurance Amount Under 1967 Act

“(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual’s primary insurance amount shall be computed on the basis of the law in effect prior to the enactment of the Social Security Amendments of 1969.

“(2) The provision of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202(a) or section 223 before March 1970, or who died before such month.”

(e) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after February 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after February 1970.

(f) If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act for February 1970 and became entitled to old-age insurance benefits under section 202(a) of such Act for March 1970, or he died in such month, then, for purposes of section 215(a)(4) of the Social Security Act (if applicable), the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as deter-

mined under section 215(c) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based.

INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER

SEC. 3. (a) (1) Section 227(a) of the Social Security Act is amended by striking out "\$40" and inserting in lieu thereof "\$44," and by striking out "\$20" and inserting in lieu thereof "\$22."

(2) Section 227(b) of such Act is amended by striking out in the second sentence "\$40" and inserting in lieu thereof "\$44".

(b) (1) Section 228(b) (1) of such Act is amended by striking out "\$40" and inserting in lieu thereof "\$44".

(2) Section 228(b) (2) of such Act is amended by striking out "\$40" and inserting in lieu thereof "\$44", and by striking out "\$20" and inserting in lieu thereof "\$22".

(3) Section 228(c) (2) of such Act is amended by striking out "\$20" and inserting in lieu thereof "\$22".

(4) Section 228(c) (3) (A) of such Act is amended by striking out "\$40" and inserting in lieu thereof "\$44".

(5) Section 228(c) (3) (B) of such Act is amended by striking out "\$20" and inserting in lieu thereof "\$22".

(c) The amendments made by subsections (a) and (b) shall apply with respect to monthly benefits under title II of the Social Security Act for months after February 1970.

AUTOMATIC ADJUSTMENT OF BENEFITS

SEC. 4. (a) Section 215 of the Social Security Act is amended by adding after subsection (h) the following new subsection:

"Cost-of-Living Increases in Benefits

"(i) (1) For purposes of this subsection—

"(A) the term 'base quarter' shall mean the period of three consecutive calendar months ending on September 30, 1969, and the period of 3 consecutive calendar months ending on September 30 of each year thereafter.

"(B) the term 'cost-of-living computation quarter' shall mean the base quarter in which the monthly average of the Consumer Price Index prepared by the Department of Labor exceeds, by not less than 3 per centum, the monthly average of such Index in the later of: (i) the 3 calendar-month period ending on September 30, 1969 or (ii) the base quarter which was most recently a cost-of-living computation quarter.

"(2) (A) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall, effective for January of the next calendar year, increase the benefit amount of each individual who for such month is entitled to benefits under section 227 or 228 and the primary insurance amount of each individual, specified in subparagraph (B) of this paragraph, by an amount derived by multiplying such amount of each such individual (including each such individual's primary insurance amount or benefit amount under section 227 or 228 as previously increased under this subparagraph) by the same per centum (rounded by the nearest one-tenth of 1 per centum) as the monthly average of the Consumer Price

Index for such cost-of-living computation quarter exceeds the monthly average of such Index for the base quarter determined after the application of clauses (i) and (ii) of paragraph (1)(B). Such increased primary insurance amount shall be considered such individual's primary insurance amount for purposes of this subsection, section 202, and section 223.

"(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply in the case of monthly benefits under this title for months after December of the calendar year in which occurred such cost-of-living computation quarter, based on the wages and self-employment income of an individual who became entitled to monthly benefits under section 202, 223, 227, or 228 (without regard to section 202(j)(1) or section 223(b)), or who died, in or before December of the calendar year in which occurred such cost-of-living computation quarter.

"(C) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall publish in the Federal Register on or before December 1 of such calendar year a determination that a benefit increase is resultantly required and the percentage thereof. He shall also publish in the Federal Register at that time a revision of the benefit table contained in subsection (a), as it may have been revised previously, pursuant to this subparagraph. Such revision shall be determined as follows:

"(i) The amount of each line of column II shall be changed to the amount shown on the corresponding line of column IV of the table in effect before this revision.

"(ii) The amount of each line of column IV shall be increased from the amount shown in the table in effect before this revision by increasing such amount by the per centum specified in subparagraph (A) of paragraph (2), raising each such increased amount, if not a multiple of \$0.10, to the next higher multiple of \$0.10.

"(iii) If the contribution and benefit base (as defined in section 230(b)) for the calendar year in which such benefit table is revised is lower than such base for the following calendar year, columns III, IV, and V shall be extended. The amount in the first additional line in column IV shall be the amount in the last line of such column as determined under clause (ii), plus \$1.00, rounding such increased amount to the nearest multiple of \$1.00. The amount of each succeeding line of column IV shall be the amount on the preceding line increased by \$1.00, until the amount on the last line of such column shall be equal to $\frac{1}{6}$ of the contribution and earnings base for the calendar year succeeding the calendar year in which such benefit table is revised, rounding such amount, if not a multiple of \$1.00, to the nearest multiple of \$1.00. The amount in each additional line of column III shall be determined so that the second figure in the last line of column III shall be $\frac{1}{12}$ of the contribution and earnings base for the calendar year following the calendar year in which such benefit table is revised, and the remaining figures in column III shall be determined in consistent mathematical intervals from column IV. The second figure in the last line of column III before the extension of the column shall be increased to a figure mathematically consistent with the figures determined in accordance with the preceding sentence. The amount on each line of column V shall be increased, to the extent

necessary, so that each such amount shall be equal to 40 per centum of the second figure in the same line of column III, plus 40 per centum of the smaller of (I) such second figure or (II) the larger of \$450 or 50 per centum of the largest figure in column III.

"(iv) The amount on each line of column V shall be increased, if necessary, so that such amount shall be at least equal to $1\frac{1}{2}$ times the amount shown on the corresponding line in column IV. Any such increased amount that is not a multiple of \$0.10 shall be increased to the next higher multiple of \$0.10."

(b) Section 203(a) of such Act is amended by striking out the period at the end of the first sentence and inserting in lieu thereof, "or" and adding the following new paragraph:

"(4) when two or more persons are entitled (without the application of section 202(j) (1) and section 223(b)) to monthly benefits under section 202 or 223 for December in the calendar year in which occurs a cost-of-living computation quarter (as defined in section 215(i) (1)) on the basis of the wages and self-employment income of such insured individual, such total of benefits for the month immediately following shall be reduced to not less than the amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section) as in effect for December for each such person by the same per centum increase as such individual's primary insurance amount (including such amount as previously increased under section 215(i) (2)) is increased and raising each such increased amount, if not a multiple of \$0.10, to the next higher multiple of \$0.10."

(c) (1) Section 202(a) of such Act is amended by striking out "(as defined in section 215(a))."

(2) Section 215(f) (4) of such Act is amended by adding at the end before the period the following: "(including a primary insurance amount as increased under subsection (i) (2))".

(3) Section 215(g) of such Act is amended by striking out "primary insurance amount" and inserting in lieu thereof "primary insurance amount (including a primary insurance amount as increased under subsection (i) (2))".

LIBERALIZATION OF EARNINGS TEST

SEC. 5. (a) (1) Paragraphs (1) and (4) (B) of section 203(f) of the Social Security Act are each amended by striking out "\$140" and inserting in lieu thereof "\$150 or the exempt amount as determined under paragraph (8)".

(2) Paragraph (1) (A) of section 203(h) of such Act is amended by striking out "\$140" and inserting in lieu thereof "\$150 or the exempt amount as determined under paragraph (8)".

(3) Paragraph (3) section 203(f) of such Act is amended to read as follows:

"(3) For purposes of paragraph (1) and subsection (h), an individual's excess earnings for a taxable year shall be 50 per centum of his earnings for such in excess of the product of \$150 or the exempt amount as determined under paragraph (8) multiplied by the number of months in such year. The excess earnings as derived under the pre-

ceding sentence, if not a multiple of \$1, shall be reduced to the next lower multiple of \$1."

(b) Subsection (f) of section 203 of such Act is amended by adding at the end thereof the following new paragraph:

"(8) (A) On or before October 1 of 1972 and of each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the exempt amount as defined in subparagraph (b) for each month in the two taxable years which end after the calendar year following the year in which such determination is made.

"(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the larger:

"(i) the product of \$150 and the ratio of (I) the average taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which a determination under subparagraph (A) is made for each such month of such particular taxable year to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1971; such product, if not a multiple of \$10, shall be rounded to the nearest multiple of \$10, or

"(ii) the exempt amount for each month in the taxable year preceding such particular taxable year;

except that the provisions in clause (i) shall not apply with respect to any taxable year unless the contribution and earnings base for such year is determined under section 230(b)(1)."

(c) Clause (B) of Section 203(f)(1) of the Social Security Act is amended to read as follows:

"(B) in which such individual was age 72 or over, excluding from such excess earnings the earnings of an individual in or after the month in which he was age 72 in the year in which he attained age 72, with the amount (if any) of an individual's self-employment income in such year being prorated in an equitable manner under regulations prescribed by the Secretary,".

(d) The amendments made by this section shall apply with respect to taxable years ending after December 1970.

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. 6. (a) (1) (A) Section 209(a)(5) of the Social Security Act is amended by inserting "and prior to 1972" after "1967".

(B) Section 209(a) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(6) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to \$9,000 with respect to employment has been paid to an individual during any calendar year after 1971 and prior to 1974, is paid to such individual during any such calendar year;

"(7) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to the contribution and earnings base (determined under section 230) with respect to employment paid to an individual during the calendar year with respect to which such contribution and earnings base was effective, is paid to such individual during such calendar year;

(2) (A) Section 211(b) (1) (E) of such Act is amended by inserting "and prior to 1972" after "1967", by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 211(b) (1) of such Act is further amended by adding at the end thereof the following new subparagraphs:

"(F) For any taxable year ending after 1971 and prior to 1974, (i) \$9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

"(G) For any taxable year ending in any calendar year after 1973, (i) an amount equal to the contribution and earnings base (as determined under section 230) effective for such calendar year, minus (ii) the amount of the wages to such individual during such taxable year, or".

(3) (A) Section 213(a) (2) (ii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and before 1972, or \$9,000 in the case of a calendar year after 1971 and before 1974, or an amount equal to the contribution and earnings base (as determined under section 230) in the case of any calendar year with respect to which such contribution and earnings base was effective".

(B) Section 213(a) (2) (iii) of such Act is amended by striking out "after 1967" and inserting in lieu thereof "after 1967 and prior to 1972, or \$9,000 in the case of a taxable year ending after 1971 and prior to 1974 or the amount equal to the contribution and earnings base, (as determined under section 230) in the case of any taxable year ending in any calendar year after 1973, effective for such calendar year".

(4) Section 215(e) (1) of such Act is amended by striking out "and the excess over \$7,800 in the case of any calendar year after 1967" and inserting in lieu thereof "the excess over \$7,800 in the case of any calendar year after 1967 and before 1972, the excess over \$9,000 in the case of any calendar year after 1971 and before 1974, and the excess over an amount equal to the contribution and earnings base (as determined under section 230) in the case of any calendar year after 1973 with respect to which such contribution and earnings base was effective".

(b) (1) (A) Section 1402(b) (1) (E) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and before 1972" after "1967", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 1402(b) (1) of such Code is further amended by adding at the end thereof the following new subparagraphs:

"(F) for any taxable year ending after 1971 and before 1974, (i) \$9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

"(G) for any taxable year ending in any calendar year after 1973, (i) an amount equal to the contribution and earnings base (as determined under section 230 of the Social Security Act) effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or".

(2) (A) Section 3121(a) (1) of such Code (relating to definition of wages) is amended by striking out "\$7,800" each place it appears and inserting in lieu thereof "\$9,000".

(B) Effective with remuneration paid after 1973, section 3121(a) (1) of such Code is amended by (1) striking out "\$9,000" each place it appears and inserting in lieu thereof "the contribution and earnings base (as determined under section 230 of the Social Security Act)", and (2) striking out "by an employer during any calendar year", and in-

serting in lieu thereof "by an employer during the calendar year with respect to which such contribution and earnings base was effective".

(3) (A) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "\$7,800" and inserting in lieu thereof "\$9,000".

(B) Effective with remuneration paid after 1973, the second sentence of section 3122 of such Code is amended by striking out "\$9,000" and inserting in lieu thereof "the contribution and earnings base".

(4) (A) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by striking out "\$7,800" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "\$9,000".

(B) Effective with remuneration paid after 1973, the second sentence of section 3125 of such Code is amended by striking out "\$9,000" where it appears in subsections (a), (b), and (c) and inserting in lieu thereof "the contribution and earnings base".

(5) Section 6413(c) (1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1972" after "after the calendar year 1967".

(B) by inserting after "exceed \$7,800" the following: "or (E) during any calendar year after the calendar year 1971 and prior to the calendar year 1974, the wages received by him during such year exceed \$9,000, or (F) during any calendar year after 1973, the wages received by him during such year exceed the contribution and earnings base (as determined under section 230 of the Social Security Act) effective with respect to such year," and

(C) by inserting before the period at the end thereof the following: "and before 1972, or which exceeds the tax with respect to the first \$9,000 of such wages received in such calendar year after 1971 and before 1974, or which exceeds the tax with respect to the first amount equal to the contribution and earnings base (as determined under section 230 of the Social Security Act) of such wages received in the calendar year after 1973 with respect to which such contribution and earnings base was effective".

(6) Section 6413(c) (2) (A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by—

(A) striking out "or \$7,800 for any calendar year after 1967" and inserting in lieu thereof "\$7,800 for the calendar year 1968, 1969, 1970 and 1971, or \$9,000 for the calendar year 1972 or 1973, or an amount equal to the contribution and earnings base (as determined under section 230 of the Social Security Act) for any calendar year after 1973 with respect to which such contribution and earnings base was effective".

(c) The amendments made by subsections (a) (1) and (a) (3) (A), and the amendments made by subsection (b) (except paragraph (1) thereof), shall apply only with respect to remuneration paid after December 1971. The amendments made by subsections (a) (2), (a) (3) (B), and (b) (1) shall apply only with respect to taxable years ending after 1971. The amendment made by subsection (a) (4) shall apply only with respect to calendar years after 1971.

AUTOMATIC ADJUSTMENT OF EARNINGS BASE

SEC. 7. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"AUTOMATIC ADJUSTMENT OF EARNINGS BASE

"SEC. 230. (a) On or before October 1 of 1972, and each even-numbered year thereafter, the Secretary shall determine and publish in the Federal Register the contribution and earnings base (as defined in subsection (b)) for the two calendar years succeeding the calendar year following the year in which the determination is made.

"(b) The contribution and earnings base for a particular calendar year shall be whichever of the following is the larger.

"(1) the product of \$9,000 and the ratio of (A) the average taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which a determination under subsection (a) is made for such particular calendar year to (B) the average of the taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of 1971; such product, if not a multiple of \$600, shall be rounded to the nearest multiple of \$600, or

"(2) the contribution and earnings base for the calendar year preceding such particular calendar year."

(b) That part of section 215(a) of the Social Security Act which precedes the table is amended by striking out "or" at the end of paragraph (3), by striking out the period at the end of paragraph (4) and inserting in lieu thereof "or the amount equal to his primary insurance amount upon which such disability insurance benefit is based if such primary insurance amount was determined under paragraph (5); or", and by inserting after paragraph (4) the following:

"(5) If such insured individual's average monthly wage (as determined under subsection (b)) exceeds \$750, the amount equal to the sum of (A) \$54.48 and (B) 28.47 per centum of such average monthly wage; such sum, if it is not a multiple of \$1, shall be rounded to the nearest multiple of \$1."

(c) So much of section 203(a) as precedes paragraph (2) is amended to read as follows:

"SEC. 203(a) Whenever the total of monthly benefits to which individuals are entitled under sections 202 and 223 for a month on the basis of the wages and self-employment income of an insured individual exceeds the larger of: (I) the amount appearing in column V of the table in section 215(a) on the line on which appears in column IV such insured individual's primary insurance amount, and (II) the amount which is equal to the sum of \$180.00 and 40 per centum of the highest average monthly wage (as determined under section 215(b)), which will produce the primary insurance amount of such individual (as determined under section 215(a)(5)), such total of monthly benefits to which such individuals are entitled shall be reduced to the larger amount determined under (I) or (II) above, whichever is applicable; except that—

"(1) when any such individuals so entitled would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance benefits on the basis of the wages and self-employment income of one or more other insured individuals, such total benefits shall not be reduced to less than the larger of:

"(A) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, but not more than the last

figure in column V of the table appearing in section 215(a), and

“(B) the amount determined under clause (II) for the highest primary insurance amount of any such insured individual (if such primary insurance amount is determined under section 215(a)(15)).”

(d)(1) Section 201(c) of the Social Security Act is amended by inserting before the last sentence the following sentence:

“The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954, which will be in effect for the following calendar year; this recommendation shall be made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Funds during such year.”

(2) Section 1817(b) of such Act is amended by inserting before the last sentence the following sentence:

“The report shall further include a recommendation as to the appropriateness of the tax rates in sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, which will be in effect for the following calendar year; this recommendation shall be made in the light of the need for the estimated income in relationship to the estimated outgo of the Trust Fund during such year”.

(e) The amendments made by subsections (b) and (c) shall apply with respect to monthly benefits for months after December 1973 and with respect to lump-sum death payments under such title in the case of deaths occurring after 1973.

CHANGES IN TAX SCHEDULES

SEC. 8. (a)(1) Section 1401(a) of the Internal Revenue Code of 1954 (relating to rate of tax on self-employment income for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (1), (2), (3), and (4) and inserting in lieu thereof the following:

“(1) in the case of any taxable year beginning after December 31, 1969, and before January 1, 1975, the tax shall be equal to 6.3 percent of the amount of the self-employment income for such taxable year;

“(2) in the case of any taxable year beginning after December 31, 1974, and before January 1, 1977, the tax shall be equal to 6.9 percent of the amount of the self-employment income for such taxable year; and

“(3) in the case of any taxable year beginning after December 31, 1976, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year.”

(2) Section 3101(a) of such Code (relating to rate of tax on employees for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (1), (2), (3), and (4) and inserting in lieu thereof the following:

“(1) with respect to wages received during the calendar years 1970, 1971, 1972, 1973 and 1974, the rate shall be 4.2 percent;

“(2) with respect to wages received during the calendar years 1975 and 1976, the rate shall be 4.6 percent;

“(3) with respect to wages received during the calendar years 1977, 1978, and 1979, the rate shall be 4.8 percent;

"(4) with respect to wages received during the calendar years 1980, 1981, 1982, 1983, 1984, 1985, and 1986, the rate shall be 4.9 percent; and

"(5) with respect to wages received after December 31, 1986, the rate shall be 5.0 percent."

(3) Section 3111(a) of such Code (relating to rate of tax on employers for purposes of old-age, survivors, and disability insurance) is amended by striking out paragraphs (1), (2), (3), and (4) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar years 1970, 1971, 1972, 1973 and 1974, the rate shall be 4.2 percent;

"(2) with respect to wages paid during the calendar years 1975 and 1976, the rate shall be 4.6 percent;

"(3) with respect to wages paid during the calendar years 1977, 1978, and 1979, the rate shall be 4.8 percent;

"(4) with respect to wages paid during the calendar years 1980, 1981, 1982, 1983, 1984, 1985, and 1986, the rate shall be 4.9 percent; and

"(5) with respect to wages paid after December 31, 1986, the rate shall be 5.0 percent."

(b) (1) Section 1401(b) of such Code (relating to rate of tax on self-employment income for purposes of hospital insurance) is amended by striking out paragraphs (1), (2), (3), (4), and (5) and inserting in lieu thereof the following:

"(1) in the case of any taxable year beginning after December 31, 1969, and before January 1, 1971, the tax shall be equal to 0.60 percent of the amount of the self-employment income for such taxable year; and

"(2) in the case of any taxable year beginning after December 31, 1970, the tax shall be equal to 0.90 percent of the amount of the self-employment income for such taxable year."

(2) Section 3101(b) of such Code (relating to rate of tax on employees for purposes of hospital insurance) is amended by striking out paragraphs (1), (2), (3), (4), and (5) and inserting in lieu thereof the following:

"(1) with respect to wages received during the calendar year 1970, the rate shall be 0.60 percent; and

"(2) with respect to wages received after December 31, 1970, the rate shall be 0.90 percent."

(3) Section 3111(b) of such Code (relating to rate of tax on employers for purposes of hospital insurance) is amended by striking out paragraphs (1), (2), (3), (4), and (5) and inserting in lieu thereof the following:

"(1) with respect to wages paid during the calendar year 1970, the rate shall be 0.60 percent; and

"(2) with respect to wages paid after December 31, 1970, the rate shall be 0.90 percent."

(c) The amendments made by subsections (a) (1) and (b) (1) shall apply only with respect to taxable years beginning after December 31, 1969. The remaining amendments made by this section shall apply only with respect to remuneration paid after December 31, 1969.

AGE-62 COMPUTATION POINT FOR MEN

SEC. 9. (a) Section 214(a) (1) of the Social Security Act is amended by striking out "before—" and by striking out all of subparagraphs (A), (B), and (C) and by inserting in lieu thereof "before the year in which he died or (if earlier) the year in which he attained age 62,".

(b) Section 215(b) (3) of such Act is amended by striking out "before—" and all of subparagraphs (A), (B), and (C) and by inserting in lieu thereof "before the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 62.".

(c) Section 215(f) of such Act is amended by striking out paragraph (5) and inserting in lieu thereof the following:

"(5) In the case of an individual who is entitled to monthly benefits for a month after December 1970, on the basis of the wages and self-employment income of an insured individual who prior to January 1971 became entitled to benefits under section 202(a), became entitled to benefits under section 223 after the year in which he attained age 62, or died in a year after the year in which he attained age 62, the Secretary shall, notwithstanding paragraphs (1) and (2), recompute the primary insurance amount of such insured individual. Such recomputation shall be made under whichever of the following alternative computation methods yields the higher primary insurance amount:

"(A) the computation methods of this section, as amended by the Social Security Amendments of 1969, which would be applicable in the case of an insured individual who attained age 62 after December 1970, or

"(B) under the provisions in subparagraph (A) (but without regard to the limitation, 'but after 1960' contained in paragraph (3) of subsection (b)), except that for any such recomputation, when the number of an individual's benefit computation years is less than 5, his average monthly wage shall, if it is in excess of \$400, be reduced to such amount."

(d) Section 223(a) (2) of such Act is amended by—

(1) striking out "(if a woman) or age 65 (if a man)",

(2) striking out "in the case of a woman" and inserting in lieu thereof "in the case of an individual", and

(3) striking out "she" and inserting in lieu thereof "he".

(e) Section 223(c) (1) (A) is amended by striking out "(if a woman) or age 65 (if a man)".

(f) The amendments made by the preceding subsections of this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1970 and with respect to lump-sum death payments made in the case of an insured individual who died after such month.

(g) Sections 209(i), 216(i) (3) (A), and 213(a) (2) of the Social Security Act are amended by striking out "(if a woman) or age 65 (if a man)".

ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN 18 AND 22

SEC. 10. (a) Clause (ii) of section 202(d) (1) (B) of the Social Security Act is amended by striking out "which began before he attained the age of 18" and inserting in lieu thereof "which began before he attained the age of 22".

(b) Subparagraphs (F) and (G) of section 202(d)(1) of such Act are amended to read as follows:

“(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

“(i) the first month during no part of which he is a full-time student, or

“(ii) the month in which he attains the age of 22, but only if he was not under a disability (as so defined) in such earlier month; or

“(G) if such child was under a disability (as so defined) at the time he attained the age of 18, or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22, the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

“(i) the first month during no part of which he is a full-time student, or

“(ii) the month in which he attains the age of 22, but only if he was not under a disability (as so defined) in such earlier month.”

(c) Section 202(d)(1) of such Act is further amended by adding at the end thereof the following new sentence: “No payment under this paragraph may be made to a child who would not meet the definition of disability in section 223(d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity.”

(d) Paragraph (6) of section 202(d) is amended by striking out “in which he is a full-time student and has not attained the age of 22” and all that follows and inserting in lieu thereof “in which he—

“(A) (i) is a full-time student or (ii) is under a disability (as defined in section 223(d)), and

“(B) had not attained the age of 22, but only if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs:

“(C) the first month in which an event specified in paragraph (1)(D) occurs; or

“(D) the earlier of (i) the first month during no part of which he is a full-time student or (ii) the month in which he attains the age of 22, but only if he is not under a disability (as so defined) in such earlier month; or

“(E) if he was under a disability (as so defined), the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

“(i) the first month during no part of which he is a full-time student, or

“(ii) the month in which he attains the age of 22.”

(e) Section 202(s) of such Act is amended—

(1) by striking out “before he attained such age” in paragraph (1) and inserting in lieu thereof “before he attained the age of 22”; and

(2) by striking out “before such child attained the age of 18” in paragraphs (2) and (3) and inserting in lieu thereof “before such child attained the age of 22”.

(f) The amendments made by this section shall apply only with respect to monthly insurance benefits payable under section 202 of the Social Security Act for months after December 1970, except that in the case of an individual who was not entitled to a monthly benefit under such section for December 1970, such amendments shall apply only on the basis of an application filed after September 30, 1970.

ALLOCATION TO DISABILITY INSURANCE TRUST FUND

SEC. 11. (a) Section 201(b)(1) of the Social Security Act is amended by—

- (1) striking out “and” at the end of clause (B);
- (2) striking out “1967, and so reported,” and inserting in lieu thereof the following: “1967, and before January 1, 1970, and so reported, and (D) 1.05 per centum of the wages (as so defined) paid after December 31, 1969, and so reported,”.
- (b) Section 201(b)(2) of such Act is amended by—
 - (1) striking out “and” at the end of clause (B);
 - (2) striking out “1967,” and inserting in lieu thereof the following: “1967, and before January 1, 1970, and (D) 0.7875 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969,”.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

SEC. 12. (a) Subsection 229(a) of such Act is amended by—

- (1) striking out “after December 1967,” and inserting in lieu thereof “after December 1970”;
- (2) striking out “after 1967” and inserting in lieu thereof “after 1956”; and
- (3) striking out all of paragraphs (1), (2), and (3), and inserting in lieu thereof “\$300”.

(b) The amendments made by subsection (a) shall apply with respect to monthly benefits payable under title II of the Social Security Act for months after December 1970, and with respect to lump-sum death payments in the case of deaths occurring after December 1970, except that, in the case of any individual who is entitled, on the basis of the wages and self-employment income of any individual to whom section 229 applies, to monthly benefits under title II of such Act for December 1970, such amendments shall apply (A) only if an application for recomputation by reason of such amendments is filed by such individual, or any other individual, entitled to benefits under such title II on the basis of such wages and self-employment income, and (B) only with respect to such benefits for months after whichever of the following is later: December 1970 or the twelfth month before the month in which such application was filed. Recomputations of benefits as required to carry out the provisions of this paragraph shall be made notwithstanding the provisions of section 215(f)(1) of the Social Security Act; but no such recomputation shall be regarded as a recomputation for purposes of section 215(f) of such Act.

PARENT'S INSURANCE BENEFITS IN CASE OF RETIRED OR DISABLED WORKER

SEC. 13. (a) Paragraphs (1) and (2) of section 202(h) of the Social Security Act are amended to read as follows:

“(1) Every parent (as defined in this subsection) of an individual entitled to old-age or disability insurance benefits, or of an individual who died a fully insured individual, if such parent—

“(A) has attained age 62,

“(B) was receiving at least one-half of his support, as determined in accordance with regulations prescribed by the Secretary, from such individual—

“(i) if such individual is entitled to old-age or disability insurance benefits, at the time he became entitled to such benefits,

“(ii) if such individual has died, at the time of such death, or

“(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he had died) until the month of his death, at the beginning of such period of disability, and has filed proof of such support within two years after the month in which such individual filed application with respect to such period of disability, became entitled to such benefits, or died, as the case may be,

“(C) is not entitled to old-age or disability insurance benefits, or is entitled to such benefits, each of which is (i) less than 50 percent of the primary insurance amount of such individual if such individual is entitled to old-age or disability insurance benefits, or (ii) less than 82½ percent of the primary insurance amount of such individual if such individual is deceased, and if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case),

“(D) has not married since the time with respect to which the Secretary determines, under subparagraph (B) of this paragraph, that such parent was receiving at least one-half of his support from such individual, and

“(E) has filed application for parent's insurance benefits, shall be entitled to a parent's insurance benefit for each month, beginning with the first month in which such parent becomes so entitled to such parent's insurance benefits and ending with the month preceding the first month in which any of the following occurs—

“(F) such parent dies or marries, or

“(G) (i) if such individual is entitled to old-age or disability insurance benefits, such parent becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or (ii) if such individual has died, such parent becomes entitled to an old-age or disability insurance benefit which is equal to or exceeds 82½ percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case), or

“(H) such individual, if living, is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

“(2)(A) Except as provided in subparagraphs (B) and (C), such parent's insurance benefit for each month shall be equal to—

(i) if the individual on the basis of whose wages and self-employment income the parent is entitled to such benefit has not died prior to the end of such month, one-half of the primary insurance amount of such individual for such month, or

“(ii) if such individual has died in or prior to such month, 82½ percent of the primary insurance amount of such deceased individual;

“(B) For any month for which more than one parent is entitled to parent’s insurance benefits on the basis of the wages and self-employment income of an individual who died in or prior to such month, such benefit for each such parent for such month shall (except as provided in subparagraph (C)) be equal to 75 percent of the primary insurance amount of such deceased individual;

“(C) In any case in which—

“(i) any parent is entitled to a parent’s insurance benefit for a month on the basis of the wages and self-employment income of an individual who died in or prior to such month, and

“(ii) another parent of such deceased individual is entitled to a parent’s insurance benefit for such month on the basis of such wages and self-employment income, and on the basis of an application filed after such month and after the month in which the application for the parent’s insurance benefits referred to in clause (i) was filed,

the amount of the parent’s insurance benefit of the parent referred to in clause (i) for the month referred to in such clause shall be determined under subparagraph (A) instead of subparagraph (B) and amount of the parent’s insurance benefit of the parent referred to in clause (ii) for such month shall be equal to 150 percent of the primary insurance amount of such individual minus the amount (before the application of section 203(a)) of the benefit for such month of the parent referred to in clause (i).

(b) Section 202(q) of such Act is amended by—

(1) inserting in paragraph (1) after “husband’s,” the following: “parent’s,” and by striking out in such paragraph (1) “or husband’s” and inserting in lieu thereof “, husband’s, or parent’s”;

(2) inserting in paragraph (3) after “husband’s,” wherever it appears the following: “parent’s” and by striking out in such paragraph (3) “or husband’s” wherever it appears and inserting in lieu thereof “husband’s, or parent’s”;

(3) inserting in paragraph (6) after “husband’s,” wherever it appears the following: “parent’s.”; and by striking out in such paragraph (6) “or husband’s” wherever it appears and inserting in lieu thereof “husband’s, or parent’s”;

(4) inserting in paragraph (7) after “husband’s,” the following: “parent’s,” and by striking out “or husband’s” and inserting in lieu thereof “husband’s, or parent’s”; and

(5) adding at the end thereof the following new paragraph:

“(10) For purposes of this subsection, ‘parent’s insurance benefits’ means benefits payable under this section to a parent on the basis of the wages and self-employment income of an individual entitled to old-age insurance benefits or disability insurance benefits.”

(c) Section 202(r) of such Act is amended—

(1) by striking out “or Husband’s” in the heading and inserting in lieu thereof, “Husband’s, or Parent’s”; and

(2) by striking out "or husband's" each time it appears in paragraphs (1) and (2) and inserting in lieu thereof, "husband's, or parent's".

(d) Section 203(d) (1) of such Act is amended by striking out "or child's" wherever it appears and inserting in lieu thereof "child's, or parent's" and by striking out "or child" and inserting in lieu thereof "child, or parent".

(e) Subparagraph (C) of section 202(q) (7) of such Act is amended—

(1) by striking out "wife's or husband's insurance benefits" and inserting in lieu thereof "wife's, husband's, or parent's insurance benefits", and

(2) by striking out "the spouse" and inserting in lieu thereof "the individual".

(f) Section 222(b) (3) of such Act is amended—

(1) by striking out "husband's, or child's" wherever it appears and inserting in lieu thereof "husband's, parent's, or child's", and

(2) by striking out "husband, or child" and inserting in lieu thereof "husband, parent, or child".

(g) Where—

(1) one or more persons were entitled (without the application of section 202(j) (1) of the Social Security Act) to monthly benefits under section 202 or 223 of such Act for December 1970 on the basis of the wages and self-employment income of an individual, and

(2) one or more persons are entitled to monthly benefits for January 1971 solely by reason of this section on the basis of such wages and self-employment income, and

(3) the total of benefits to which all persons are entitled under such section 202 or 223 on the basis of such wages and self-employment income for January 1971 is reduced by reason of section 203(a) of such Act, as amended by this Act (or would, but for the penultimate sentence of such section 203(a), be so reduced), then the amount of the benefit to which each person referred to in paragraph (1) of the subsection is entitled for months after December 1970 shall be increased, after the application of such section 203(a), to the amount it would have been if the person or persons referred to in paragraph (2) were not entitled to a benefit referred to in such paragraph (2).

(h) The amendments made by this section shall apply only with respect to monthly insurance benefits payable under Section 202 of the Social Security Act for months after December 1970 and only on the basis of an application filed after September 30, 1970.

(i) The requirement in section 202(h) (1) (B) of the Social Security Act that proof of support be filed within two years after a specified date in order to establish eligibility for parent's insurance benefits shall, insofar as such requirement applies to cases where applications under such subsection are filed by parents on the basis of the wages and self-employment income of an individual entitled to old-age or disability insurance benefits, not apply if such proof of support is filed within two years after the date of enactment of this Act.

INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

SEC. 14. (a) Subsection (e) of section 202 of the Social Security Act is amended as follows:

(1) Paragraphs (1) and (2) of such subsection are amended by striking out "82½ per cent of" wherever it appears.

(2) Paragraph (5) of such subsection is amended by striking out "60" and inserting in lieu thereof "65."

(b) Subsection (f) of section 202 of such Act is amended as follows:

(1) Paragraphs (1) and (3) of such subsection are amended by striking out "82½ percent of" wherever it appears.

(2) Paragraph (6) of such subsection is amended by striking out "62" and inserting in lieu thereof "65."

(c) (1) The last sentence of subsection (c) of section 203 of such Act is amended by striking out all that follows the semicolon and inserting in lieu thereof the following: "nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained age 65 (but only if she became so entitled prior to attaining age 60), or from any widower's insurance benefit for any month in which the widower is entitled and has not attained age 65 (but only if he became so entitled prior to attaining age 62).".

(2) Subparagraph (D) of section 203(f) (1) of such Act is amended to read as follows:

"(D) for which individual is entitled to widow's insurance benefits and has not attained age 65 (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained age 65 (but only if he became so entitled prior to attaining age 62), or".

(d) Subsection (q) of section 202 of such Act, as amended by this Act, is further amended as follows:

(1) That part of paragraph (1) of such subsection which precedes subparagraph (C) is amended to read as follows:

"(q) (1) If the first month for which an individual is entitled to an old-age, wife's, husband's, parent's, widow's, or widower's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for each month shall, subject to the succeeding paragraphs of this subsection, be reduced—

"(A) for each month of such entitlement within the 36-month period immediately preceding the month in which such individual attains retirement age, by

"(i) 5/9 of 1 percent of such amount if such benefit is an old-age insurance benefit, 25/36 of 1 percent of such amount if such benefit is a wife's, husband's, or parent's insurance benefit, or 35/72 of 1 percent of such amount if such benefit is a widow's or widower's insurance benefit, multiplied by

"(ii) the number of such months in (I) the reduction period for such benefit (determined under paragraph (6) (A)), if such benefit is for a month before the month in which such individual attains retirement age, or (II) the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is for the month in which such individual attains retirement age or for any month thereafter, and—

"(B) for each month of the 24-month period for which a widow, or widower, is entitled to a widow's or widower's insurance benefit immediately preceding the month in which such individual attains age 62, the amount of such individual's widow's

or widower's benefit as reduced under subparagraph (A) shall be further reduced by—

“(i) $\frac{5}{8}$ of 1 percent of such reduced benefit, multiplied by

“(ii) the number of such months in (I) the reduction period for such benefit, if such benefit is for a month before the month in which such individual attains age 62, or (II) the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is for the month in which such individual attains retirement age or for any month thereafter.

“A widow's or widower's insurance benefit reduced pursuant to the preceding sentence shall be further reduced by—”.

(2) Paragraph (2) of such subsection is amended by striking out “paragraphs (1) and (4)” and inserting in lieu thereof “paragraphs (1), (3), and (4)”.

(3) Paragraph (3) of such subsection is amended by—

(A) striking out subparagraph (F), and

(B) redesignating subparagraph (G) as subparagraph (F), striking out of such subparagraph “(when such first month occurs before the month in which such individual attains the age of 62)”, and striking out “age 62” and inserting in lieu thereof “age 65”.

(4) Paragraph (9) of such subsection is amended to read as follows:

“(9) For purposes of this subsection, the term ‘retirement age’ means age 65.”.

(e) Subsection (r) of section 202 of such Act, as amended by this Act, is further amended as follows:

(1) by striking out “Husband's, or Parent's” in the heading and inserting in lieu thereof “Husband's, Parent's, Widow's, or Widower's”; and

(2) by striking out “husband's, or parent's” each time it appears in paragraphs (1) and (2) and inserting in lieu thereof “husband's, parent's, widows, or widower's”.

(f) In the case of an individual who is entitled (without the application of section 202(j)(1) and 223(b)) to widow's or widower's insurance benefits for the month of December 1970, if such individual's entitlement to such benefits began with a month after the month he attained age 62, the Secretary shall redetermine the amount of such benefits under the provisions of this section as if these provisions had been in effect for the first month of such individual's entitlement to such benefits.

(g) The amendments made by this section shall be effective for monthly benefits for months after December 1970.

COST ESTIMATES

SEPTEMBER 25, 1969.

Memorandum.

To: Mr. Robert M. Ball, Commissioner of Social Security.

From: Robert J. Myers, Chief Actuary.

Subject: Summary results of new cost estimates for present OASDI and HI systems and for President's proposal.

This memorandum will summarize the results of the new cost estimates for the old-age, survivors, and disability insurance system that have just now been completed. At the same time, it is essential that the current actuarial situation of the Hospital Insurance system should be considered simultaneously. Although the revision of the HI cost estimates has not yet been completed, preliminary estimates have been made, and these should be close to the final results that will be produced subsequently. Information will also be presented as to the cost aspects of the proposal just made by President Nixon.

It will be recalled that the cost estimates for the OASDI system which were contained in the 1969 Trustees Report showed a positive long-range actuarial balance (that is, a financial surplus) of 53 percent of taxable payroll. The new cost estimates show that this positive balance is increased to 1.16 percent of taxable payroll. The principal reasons for this change, and the amount that each contributes to the increase of .63 percent of taxable payroll in the financial surplus, are as follows:

(1) The use of a higher earnings-level assumption (namely, 1969 earnings as against 1968 earnings)—.22 percent of taxable payroll.

(2) The use of a higher interest-rate assumption (namely, $4\frac{3}{4}$ percent as against $4\frac{1}{4}$ percent)—.11 percent of taxable payroll.

(3) The use of higher labor-force participation rates for both men and women (based on recent actual experience), which, because of the weighted benefit formula and the provision preventing, in essence, receipt of benefits on more than one earnings record, results in a greater increase in estimated income than in estimated outgo—.23 percent of taxable payroll.

(4) Update of other factors—.07 percent of taxable payroll.

Now, turning to the cost estimates for the HI system, it will be recalled that the estimates contained in the 1969 Trustees Report showed a negative long-range actuarial balance (that is, a financial deficit) of .29 percent of taxable payroll. The preliminary new cost estimates show that this negative balance has become larger—namely, —.77 percent of taxable payroll. The principal reasons for this change are as follows:

(1) The use of higher hospital utilization rates as the initial 1969 base and the introduction of an assumption that these rates will increase gradually over the next decade (at an average annual rate of about 1 percent), both of which assumptions are

based on an extensive analysis of recent operating experience.

(2) The use of higher assumed increases in hospital per diem costs than previously assumed (namely, 15 percent for 1969, 14 percent for 1970, 13 percent for 1971, grading down to 4 percent after 1977, as compared with the previous assumption of 12 percent for 1969, 9 percent for 1970, 7½ percent for 1971, grading down to 3½ percent after 1974), which assumption is based on analysis and projection of recent operating and other experience.

Offsetting slightly the foregoing increased-cost assumptions for the HI cost estimates are several other changed assumptions, including the following:

(1) The use of a higher interest rate (namely, 5 percent as against 4½ percent).

(2) A reduction in the estimated cost of the extended care facility benefits (since the previous estimate seems to have included the assumption of too rapid an increase in the utilization of such benefits).

(3) As in the OASDI estimates, higher labor-force participation rates and a higher initial payroll-tax base and higher assumed increases in future earnings levels (for example, ultimately, 4 percent per year as against 3½ percent used previously).

Finally, I might point out that an increase in the taxable earnings base from the present \$7,800 per year would have a favorable effect on the financing of both the OASDI and HI systems. For example, a change to \$9,000 would increase the positive actuarial balance of the OASDI system by .23 percent of taxable payroll and would decrease the negative actuarial balance of the HI system of .17 percent of taxable payroll.

President Nixon has proposed that the benefit provisions of the OASDI system should be changed in the following manner:

(1) An across-the-board benefit increase of 10 percent.

(2) A modification of the retirement test, so that the annual exempt amount would be increased from \$1,680 to \$1,800, and the "\$1 for \$2" reduction would apply to all earnings in excess of the annual exempt amount (instead of only to the first \$1,200 above the normal exempt amount, as in present law).

(3) Payment of dependent parent's benefits with respect to old-age beneficiaries and disability beneficiaries.

(4) Increase from age 18 to age 22 the limit before which adult children must have been disabled in order to receive child's benefits.

(5) Modify the retirement test as it applies to the year of attainment of age 72, so that earnings in and after the month of attainment are not counted against the annual test.

(6) Have an age-62 computation point for men, instead of age 65 (that is, having the same point for men that women have under present law).

(7) Pay widow's benefits of 100 percent of the PIA when first payable at or after age 65, graded down to 82½ percent when first claimed at age 62.

(8) Increase in the taxable earnings base from \$7,800 to \$9,000, effective for 1972; thereafter, automatic adjustment of the earnings base in accordance with changes in the level of wages in covered employment.

(9) Automatic adjustment of the OASDI benefits in accordance with changes in the cost of living and automatic adjustment of the annual exempt amount of the retirement test in accordance with changes in the level of wages in covered employment; insofar as the OASDI system is concerned, the cost of these benefit changes would be financed by the automatic adjustment of the earnings base, while insofar as the HI system is concerned, the additional financing due to the automatic adjustment of the earnings base would have a significant effect on its actuarial status.

(10) Changes in the contribution schedules, as shown in table I. Under the President's proposal, the long-range actuarial balance of the OASDI system is estimated to be $-.09$ percent of taxable payroll, while the corresponding figure for the HI program is $+.06$ percent of taxable payroll. Both of these relatively small balances are within the limits generally acceptable, and so the proposal is in actuarial balance.

Table 2 shows the progress of the combined OASI and DI trust funds and of the HI trust fund for fiscal years 1970-73 under present law. Table 3 gives similar data for the President's proposal.

ROBERT J. MYERS.

TABLE 1.—COMPARISON OF PRESENT AND PROPOSED CONTRIBUTION SCHEDULES

[In percent]

Period	Combined employer-employee		Self-employed	
	Present	Proposed	Present	Proposed
OASDI rate:				
1970.....	8.4	8.4	6.3	6.3
1971-72.....	9.2	8.4	6.9	6.3
1973-74.....	10.0	8.4	7.0	6.3
1975-76.....	10.0	9.2	7.0	6.9
1977-79.....	10.0	9.6	7.0	7.0
1980-86.....	10.0	9.8	7.0	7.0
1987 and after.....	10.0	10.0	7.0	7.0
HI rate:				
1970.....	1.2	1.2	.6	.6
1971-72.....	1.2	1.8	.6	.9
1973-74.....	1.3	1.8	.65	.9
1975.....	1.3	1.8	.7	.9
1976-79.....	1.4	1.8	.7	.9
1980-86.....	1.6	1.8	.8	.9
1987 and after.....	1.8	1.8	.9	.9
Combined OASDI-HI rate:				
1970.....	9.6	9.6	6.9	6.9
1971-72.....	10.4	10.2	7.5	7.2
1973-74.....	11.3	10.2	7.65	7.2
1975.....	11.3	11.0	7.65	7.8
1976.....	11.4	11.0	7.7	7.8
1977-79.....	11.4	11.4	7.7	7.9
1980-86.....	11.6	11.6	7.8	7.9
1987 and after.....	11.8	11.8	7.9	7.9

TABLE 2.—ESTIMATED SHORT-RANGE PROGRESS OF TRUST FUNDS UNDER PRESENT LAW

[In billions]

Fiscal year	Contribution income	Other income ¹	Benefit outgo	Other outgo ²	Net income	Fund at end of year
OASDI trust funds:						
1970-----	\$33.4	\$1.8	\$27.3	\$1.2	\$6.8	\$38.7
1971-----	36.3	2.3	28.4	1.2	8.9	47.6
1972-----	40.3	2.8	29.6	1.2	12.3	59.9
1973-----	43.9	3.5	30.7	1.3	15.4	75.3
HI trust fund:						
1970-----	4.7	.8	5.2	.1	.2	2.2
1971-----	4.9	1.0	6.2	.1	-.5	1.7
1972-----	5.2	.8	7.3	.1	-1.5	.2
1973-----	5.6	.7	8.5	.1	-2.2	-----

¹ Interest income, payments from general fund for noninsured persons and military service wage credits, and (for HI) payments from railroad retirement system.

² Administrative expenses and (for OASDI) payments to railroad retirement system.

TABLE 3.—ESTIMATED SHORT-RANGE PROGRESS OF TRUST FUNDS UNDER PROPOSAL

[In billions]

Fiscal year	Contribution income	Other income ¹	Benefit outgo	Other outgo ²	Net income	Fund at end of year
OASDI trust funds:						
1970-----	\$33.4	\$1.8	\$28.0	\$1.2	\$6.1	\$38.0
1971-----	34.7	2.1	31.6	1.3	3.9	41.9
1972-----	37.0	2.3	34.0	1.4	3.9	45.7
1973-----	40.8	2.6	35.2	1.4	6.8	52.6
HI trust fund:						
1970-----	4.7	.8	5.2	.1	.2	2.2
1971-----	6.0	1.1	6.2	.1	.7	2.9
1972-----	7.8	.9	7.3	.1	1.2	4.2
1973-----	8.6	1.0	8.5	.1	1.0	5.2

¹ Interest income, payments from general fund for noninsured persons and military service wage credits, and (for HI) payments from railroad retirement system.

² Administrative expenses and (for OASDI) payments to railroad retirement system.

Explanation of the Bill

STATEMENT OF SECRETARY OF HEALTH, EDUCATION, AND WELFARE ROBERT H. FINCH IN EXPLANATION OF THE PROPOSED FAMILY AS- SISTANCE ACT OF 1969

The family assistance plan is a revolutionary effort to reform a welfare system in crisis. With this program and the administration's proposed food stamp plan, the Federal Government launches a new strategy—an income strategy—to deal with our most critical domestic problems. For those among the poor who can become self-supporting, this strategy offers an avenue to greater income through expanded work incentives, training, and employment opportunities. For those who cannot work, there is a more adequate level of Federal support.

If the family assistance and food stamp proposals are enacted, we will have reduced the poverty gap in this country by some 59 percent. In other words, these two programs taken together will cut by almost 60 percent the difference between the total income of all poor Americans and the total amount they would have to earn in order to rise out of poverty. In one particular category of the poor, that of couples over 65 years of age, the family assistance plan will in fact raise recipients' incomes above the poverty line altogether. This income strategy includes an administration proposal for a 10-percent increase in social security benefits, coupled with an automatic cost of living escalator. This is a real war on poverty and not just a skirmish.

I. THE FAILURE OF WELFARE

In August 8 the President addressed the Nation and called the present welfare system a failure. He said:

"Whether measured by the anguish of the poor themselves, or by the drastically mounting burden on the taxpayer, the present welfare system has to be judged a colossal failure. * * *

"What began on a small scale in the depression 1930's has become a huge monster in the prosperous 1960's. And the tragedy is not only that it is bringing States and cities to the brink of financial disaster, but also that it is failing to meet the elementary human, social, and financial needs of the poor."

The failure of the system is most evident in the recent increases in welfare costs and caseloads. In this decade alone, total costs for the four federally aided welfare programs have more than doubled, to a level now of about \$6 billion.

In the aid for families with dependent children program (AFDC), costs have more than tripled since 1960 (to about \$4 billion at the present time) and the number of recipients has more than doubled (to some 6.2 million persons). Even more disturbing is the fact that the proportion of persons on AFDC is growing. In the 15 years since 1955, the proportion of children receiving assistance has doubled—from 30 children per 1,000 to about 60 per 1,000 at present.

Prospects for the future show no likelihood for relief from the present upward spiral. By conservative estimates, AFDC costs will double again by fiscal year 1975, and caseloads will increase by 50 to 60 percent. Yet, the great irony is that despite these crushing costs, benefits remain below adequate levels in most States.

Moreover, the present AFDC program is built to fail. It embodies a set of inequities which help to cause its own destruction. First, it is characterized by unjustifiable discrepancies as between regions of the country. With no national standards for benefit levels and eligibility practices, AFDC payments now vary from an average of \$39 per month for a family of four in Mississippi to \$263 for such a family in New Jersey.

Second, it is inequitable in its treatment of male-headed families as opposed to those headed by a female. In no State is a male-headed family, where the mother is also in the home and the father is working full time for poverty wages, eligible for AFDC. In half the States, even families headed by unemployed males are still not eligible under the AFDC-UF program. On the other hand, families in poverty headed by women working full or part time are almost universally covered. The result of this unfortunate discrimination is the creation of a powerful economic incentive for the father to leave home so that the State may better support his family than he can. For example, if a father employed full time in a low wage job is able to earn only \$2,000 per year, and welfare in the State would pay a fatherless family \$3,000 per year, his wife and children are financially 50 percent better off if he leaves home. And this financial incentive has taken its toll. In 1940, only 30 percent of the families on AFDC had absent fathers, but today the figure stands at over 70 percent.

Third, AFDC imposes inequities between those who work and those who do not. Because families in poverty headed by working men are not covered, it is easily possible for such a working family to be less well off than the welfare family. And what could be more debilitating to the motivation to work to see the opportunity for one's family to be better off on welfare? Moreover, the present system further undercuts the incentive to work by reducing welfare payments too rapidly and by too much as the head of the household begins to work.

II. THE FAMILY ASSISTANCE PLAN

This administration began its formal inquiries into welfare reform even before the inauguration. From the report of the transition task force on welfare to the present time, a number of reform proposals have been considered. The final result reflects the best efforts of many different people in and out of government and in different Federal agencies.

This analysis led us to the conclusion that revolutionary structural reform in the system is required. The first priority of the family assistance plan has been to remove, or at least minimize the inequities of present welfare policies. It is designed to strengthen family life and incentives for employment. This strategy may not pay off immediately, but unless this investment is made now, fundamental reform will be even more expensive in the future.

The family assistance plan provides fiscal relief for hard-pressed States and at the same time raises benefit levels for recipients in those

areas where they are lowest. Of the \$2.9 billion made available in new funds under the plan for benefits to families and to aged, blind and disabled adults, an estimated \$700 million will have the effect of providing fiscal relief for the States and about \$300 million will be for benefit increases for present recipients. But these goals, it must be said, cannot be our first priority at the present time. There are others who would invest more of our available resources in benefit increases or in a federalization of the program designed to provide maximum fiscal relief to the States. These are not easy priorities to weigh and balance, but we have concluded that—while those other approaches might be politically more popular in many respects—they only pour more Federal money into a system doomed to failure. The system must be changed, not just its payment levels or the division of labor between the Federal and State governments within it.

The technical operation of the family assistance plan is described in the attached summary. This memorandum will review its major purposes.

First, it combines powerful work requirements and work incentives for employable recipients. By including the working poor—families in poverty headed by men working full time—the new plan much reduces and in many cases eliminates the inequity of treatment between those who work and those who do not. Second, by making it possible for a family to earn \$60 per month without any reduction of benefits, a recipient will have a strong financial incentive to enter employment and will be able to recoup his expenses of going to work without a drop in total income. Third, the program includes a strong work requirement: those able-bodied persons who refuse a training or suitable job opportunity lose their benefits. For this reason, the program is not a guaranteed annual income. It does not guarantee benefits to persons regardless of their attitudes; its support is reserved to those who are willing to support themselves. The work requirement is made effective by a new obligation of work registration. In order to be eligible for benefits, applicants must first register with their employment service office so that training and job opportunities can be efficiently communicated to them. Mothers with children under 6 are, however, exempted from this requirement of work and work registration and may elect to stay at home with their children without any loss in benefits.

Second, the family assistance plan treats male and female-headed families equally. All families with children, whether headed by a male or female, will receive benefits if family income and resources are below the national eligibility levels. From this structural change in coverage flows one of the key advantages of the program in terms of family stability. No longer would an unemployed father have to leave the home for his family to qualify for benefits. In fact, the family is better off with him at home since its benefits are increased by his presence. And for employed men, the system greatly reduces and in some cases reverses the financial incentive to desert. In the example cited above of the father earning \$2,000 in a State where his family would receive \$3,000 on welfare, the family assistance plan would supplement his wages by \$960, giving the family \$2,960 in income and eliminating the financial incentive for the father to leave home.

Third, the program establishes a national minimum payment and national eligibility standards and methods of administration. For a dependent family of four, the Federal benefit floor will be \$1,600 per year. When benefits under the President's food stamp proposal are also taken into account, the assistance package for such a family is about \$2,350 per year, or more than two-thirds of the poverty line as it has been most recently redefined. This is not, of course, a sufficient amount to sustain an adequate level of life for those who have no other income; it is, nevertheless, a substantial improvement and can be made more adequate as budget conditions permit. As a result of the establishment of the Federal benefit floor of \$1,600, payment levels will be raised in 10 States and for about 20 percent of present recipients.

For the aged, blind, and disabled, a nationwide income floor would be set at \$90 per month per person of benefits plus other income. This comes on a yearly basis to \$2,160 for two persons, an amount which is actually above the poverty line for an aged couple. This represents an important change which we have made in the program since the President announced it on August 8, when the minimum for the adult categories was set at \$65.

Perhaps at least as important as the establishment of national minimum benefit levels, however, is the provision of national eligibility standards and administrative procedures to govern the family assistance and State supplementary payment programs. For the first time, a single set of rules will apply throughout the Nation, although the States will remain free to administer their supplementary payment programs under these uniform rules if they so desire. (The preexisting State standards of need and payment levels will still continue to control in the supplementary payment programs with regard to eligibility and amount of benefits.)

States will be given the option, for both the supplementary payment and the adult category programs, to contract with the Social Security Administration for Federal assumption of some or all of the administrative burdens under these programs. In this way, we should be able to move toward a single administrative mechanism for transfer payments, taking advantage of all the economies of scale which such an automated and nationally administered system can have. The eventual transfer of the food stamp program to the Department of Health, Education, and Welfare—as previously proposed by the administration—should further enhance this administrative simplification.

Fourth, the plan includes over \$600 million for a major expansion of training and day care opportunities. Some 150,000 new training opportunities will be funded under the legislation, which, when combined with the proposed Manpower Training Act in a simplified and decentralized framework, should greatly broaden the opportunities for self-support for recipients. Some 450,000 quality child care positions are also funded in a new and flexible program which further extends the administration's commitment to the first 5 years of life.

Fifth, the family assistance plan provides major fiscal relief for the States. An estimated \$700 million of the \$2.9 billion in new Federal money being made available for expanded cash assistance will go to the States in the form of savings on their existing welfare costs. For

5 years from the date of enactment, every State is assured fiscal relief at least equal to 10 percent of what its costs would have been under the old welfare program. When these savings are combined with the new money going to the States through the training and child care components and through the separate revenue sharing program, major relief for State governments is produced. In particular, by including the working poor within the family assistance plan, we are establishing a wholly Federal responsibility for a category of potential recipients which an increasing number of States are beginning to assist at their own initiative. Some seven States now have statewide programs of relief for the working poor and another eight States have local or experimental programs directed to these people—all entirely at State expense. By establishing a Federal program to cover the working poor, we are relieving the States of what seems to be the next likely increase in costs and coverage.

III. IMPACT ON OTHER PROGRAMS

The family assistance plan has a major impact on several other Federal programs bearing on the poor.

First, we have changed the treatment of unearned income compared to the present welfare system so that the recipient of family assistance benefits loses only 50 cents from his benefit for each dollar of unearned income received. This results in the elimination of an important inequity which, for example, would make a female-headed family of four ineligible for family assistance benefits if it received \$1,700 per year in alimony or support payments, but would pay that family a benefit if the husband were at home and earning \$1,700 per year. It also has an important impact on other Federal programs such as Old Age, Survivors and Disability Insurance, and Unemployment Insurance by eliminating the dollar-for-dollar loss in benefits under welfare as income from these other programs is received.

Second, this legislation amends title XIX (medicaid) to extend mandatory coverage under that program to the AFDC-UF category. It is not possible at this time to include the working poor adults in medicaid even though they are added to public assistance coverage under family assistance.

Third, family assistance has been carefully harmonized with the food stamp program. As has already been stated, the benefits under these two programs are additive, so that a family of four receives a package of family assistance and food stamp subsidies totaling about \$2,350. Moreover, the eligibility ceilings have been set at virtually the same point—\$4,000 for a family of four—and both programs would now extend coverage to the working poor.

Finally, certain changes in the programs of services for AFDC recipients under title IV of the Social Security Act are necessitated as a result of the family assistance plan. The Department of Health, Education, and Welfare will be submitting more comprehensive amendments on the service program shortly. These amendments will include an expanded program of assistance to the States for foster care. In the meantime, however, we are leaving the present AFDC services provisions intact and retaining the 75 percent Federal matching for the financing of these programs.

Summary of the Bill

SUMMARY OF PROPOSED FAMILY ASSISTANCE ACT OF 1969

TITLE I—FAMILY ASSISTANCE PLAN

ESTABLISHMENT OF PLAN

Section 101 of the bill adds new parts D, E, and F to title IV of the Social Security Act, establishing a new family assistance plan providing for payment of family assistance benefits by the Secretary of Health, Education, and Welfare and supplementary payments by the States.

Eligibility and amount

The new part D of title IV of the Social Security Act authorizes benefits to families with children payable at the rate of \$500 per year for each of the first two members of a family plus \$300 for each additional member.

The family assistance benefit would be reduced by nonexcluded income, so that families with more nonexcludable income than these benefits (\$1,600 for a family of four) would not be eligible for any benefits.

A family with more than \$1,500 in resources, other than the home, household goods, personal effects, and other property essential to the family's capacity for self-support, would also not be eligible.

Countable income would include both earned income (remuneration for employment and net earnings from self-employment) and unearned income.

In determining income the following would be excluded (subject, in some cases, to limitations by the Secretary) :

- (1) All income of a student;
- (2) Inconsequential or infrequent or irregular income;
- (3) Income needed to offset necessary child care costs while in training or working;
- (4) Earned income of the family at the rate of \$720 per year plus one-half the remainder;
- (5) Food stamps and other public assistance or private charity;
- (6) Special training incentives and allowances;
- (7) The tuition portion of scholarships and fellowships;
- (8) Home produced and consumed produce;
- (9) One-half of other unearned income.

Veterans pensions, farm price supports, and soil bank payments would not be excludable income to any extent and would, therefore, result in reduction of benefits on a dollar-for-dollar basis.

Eligibility for and amount of benefits would be determined quarterly on the basis of estimates of income for the quarter, made in the light of the preceding period's income as modified in the light of changes in circumstances and conditions.

Definition of family and child

To qualify for family assistance plan benefits a family must consist of two or more related individuals living in their own home and residing in the United States and one must be an unmarried child (i.e., under the age of 18, or under the age of 21 and regularly attending school).

Payment of benefits

Payment may be made to any one or more members of the qualified family. The Secretary would prescribe regulations regarding the filing of applications and supplying of data to determine eligibility of a family and the amounts for which the family is eligible. Beneficiaries would be required to report events or changes of circumstances affecting eligibility or the amount of benefits.

When reports by beneficiaries are delayed too long or are too inaccurate, part or all of the resulting benefit payments could be treated as recoverable overpayments.

Registration for work and referral for training

Eligible adult family members would be required to register with public employment offices for manpower services and training or employment unless they belong to specified excepted groups. However, a person in an excepted group may register if he wishes.

The exceptions are: (1) ill, incapacitated, or aged persons; (2) the caretaker relative (usually the mother) of a child under six; (3) the mother or other female caretaker of the child if an adult male (usually the father) who would have to register is there; (4) the caretaker for an ill household member; and (5) full-time workers.

Where the individual is disabled, referral for rehabilitation services would be made. Provision is also made for child care services to the extent the Secretary finds necessary in case of participation in manpower services, training, or employment.

Denial of benefits

Family assistance benefits would be denied with respect to any member of a family who refuses without good cause to register or to participate in suitable manpower services, training, or employment. If the member is the only adult, he would be included as a family member but only for purposes of determining eligibility of the family. Also, in appropriate cases, the remaining portion of the family assistance benefit would be paid to an interested person outside the family.

On-the-job training

The Secretary would transfer to the Department of Labor funds which would otherwise be paid to families participating in employer-compensated on-the-job training if they were not participating. These funds would be available to pay the training costs involved.

STATE SUPPLEMENTATION OF FAMILY ASSISTANCE BENEFITS

Required supplementation

The individual States would have to agree to supplement the family assistance benefits under a new part E of title IV of the Social Se-

curity Act wherever the family assistance benefit level is below the previously existing Aid to Families with Dependent Children (AFDC) payment level. This supplementation is a condition which the State must meet in order to continue to receive Federal payments with respect to maternal and child health and crippled children's services (title V) and with respect to their State plans for aid to the aged, blind, and disabled (title XVI), medical assistance (title XIX), and services to needy families with children (part A of title IV). Such "supplementation" would be required to families eligible for family assistance benefits other than families where both parents are present, neither is incapacitated, or the father is not unemployed. The States would thus be required to supplement in the case of individuals eligible under the old AFDC and AFDC-UF provisions; they would not have to supplement in case of the working poor.

Amount of supplementation

Except as indicated below and, except for use of the State standard of need and payment maximums, eligibility for and amount of supplementary payments would be determined by use of the rules applicable for family assistance benefits.

In applying the family assistance rules to the disregarding of income under the supplementary payment program—

(1) in the case of earned income of the family, the State would first disregard income at the rate of \$720 per year, and would then be permitted to reduce its supplementary payment by $16\frac{2}{3}$ cents for every dollar of earnings over the range of earnings between \$720 per year and the cutoff point for family assistance (i.e., \$3,920 for a family of four), and could further reduce its supplementary payments by an amount equal to not more than 80 cents for every dollar of earnings beyond that family assistance cutoff point.

(2) in the case of unearned income, these same percentage reductions would apply, although the initial \$720 exclusion would not apply.

Requirements for agreements

Some of the State plan requirements now applicable in the case of Aid and Services to Needy Families with Children would be made applicable to the agreement. These include the requirements relating to:

- (1) statewideness;
- (2) administration by a single State agency;
- (3) fair hearing to dissatisfied claimants;
- (4) methods of administration needed for proper and efficient operation, including personnel standards, training, and effective use of subprofessional staff;
- (5) reporting to Secretary as required;
- (6) confidentiality of information relating to applicants and recipients;
- (7) opportunity to apply for and prompt furnishing of supplementary payments.

Payments to States

A State agreeing to make the supplementary payments would be guaranteed that its expenditures for the first 5 full fiscal years after

enactment would be no more than 90 percent of the amount they would have been if the family assistance plan amendments had not been enacted. This would be accomplished by Federal payment to each State, for each year, of the excess of—

(1) the total of its supplementary payments for the year plus the State share of its expenditures called for under its existing State plan approved under title XVI plus the additional expenditures required by the new title XVI, over

(2) 90 percent of the State share of what its expenditures would have been in the form of maintenance payments for such year if the State's approved plans under titles I, IV (A), X, XIV, and XVI had continued in effect (assuming in the case of the part A of title IV plan, payments for dependent children of unemployed fathers).

On the other hand, any State spending less than 50 percent of the State share, referred to in clause (2) above, for supplementary payments and its title XVI plan would be required to pay the amount of the deficiency to the Federal treasury.

A State would also receive one-half of its cost of administration under its agreement.

ADMINISTRATION

Agreements with States

Sufficient latitude is provided to deal with the individual administrative characteristics of the States. Provision is made under which the Secretary can agree to administer and disburse the supplementary payments on behalf of the States. Similarly the States can agree to administer portions of the family assistance plan on behalf of the Secretary, with respect to all or specified families in the States.

Evaluation, research, training

The Secretary would make an annual report to Congress on the new family assistance plan, including an evaluation of its operation. He would also have authority to make periodic evaluations of its operation and to use part of the program funds for this purpose.

Research into and demonstrations of better ways of carrying out the purposes of the new plan, as well as technical assistance to the States and training of their personnel who are involved in making supplementary payments, would also be authorized.

Special provisions for Puerto Rico, the Virgin Islands, and Guam

There are special provisions for these areas under which the amount of family assistance benefits, the \$720 of earned income to be disregarded, and several other amounts under the family assistance plan and the new title XVI of the Social Security Act (aid to the aged, blind, and disabled) would be reduced to the extent that the per capita income of these areas is below that of that one of the 50 States which had the lowest per capita income.

TRAINING, EMPLOYMENT, AND DAY-CARE PROGRAMS

Section 102 of the administration bill would replace part C of title IV of the Social Security Act in its entirety.

Purpose

The purpose of the revised part C is to provide manpower services, training, and employment, and child care and related services for in-

dividuals eligible for the new family assistance plan benefits (new part D) or State supplementary payments (new part E) to help them secure or retain employment or advancement in employment. The intent is to do this in a manner which will restore families with dependent children to self-supporting, independent, and useful roles in the community.

Operation

The Secretary of Labor is required to develop an employability plan for each individual required to register under the new part D or receiving supplementary payments pursuant to the new part E. The plan would describe the manpower services, training, and employment to be provided and needed to enable the individual to become self-supporting or attain advancement in employment.

Allowances

The Secretary of Labor would pay an incentive training allowance of \$30 per month to each member of a family participating in manpower training. Where training allowances for a family under another program would be larger than their benefits under the family assistance plan and supplementary State payments, the incentive allowances for the family would be equal to the difference, or \$30 per member, whichever is larger.

Allowances for transportation and other expenses would also be authorized.

These incentive and other allowances would be in lieu of allowances under other manpower training programs.

Allowances would not be payable to individuals participating in employer compensated on-the-job training.

Denial of allowances

Allowances would not be payable to an individual who refuses to accept manpower training without good cause. The individual would receive reasonable notice and have an opportunity for a hearing if dissatisfied with the denial.

Utilization of other programs

In order to avoid the creation of duplicative programs, maximum use of authorities under other acts would be made by the Secretary of Labor in providing the manpower training and related services under the revised part C, but subject to all duties and responsibilities under such other programs. Part C appropriations could be used to pay the cost of services provided by other programs and to reimburse other public agencies for services they provided to persons under part C. The emphasis is on an integrated and comprehensive manpower training program involving all sectors of the economy and all levels of government to make maximum use of existing manpower and manpower-related programs.

Appropriations and administration

Appropriations to the Secretary of Labor would be authorized for carrying out the revised part C, including payment of up to 90 percent of the cost of training and employment services provided individuals registered under the family assistance plan. The Secretary would seek to achieve equitable geographical distribution of these funds.

In developing policies and programs for manpower services, training and employment for individuals registered under the family assistance plan, the Secretary of Labor would have to first obtain the concurrence of the Secretary of Health, Education, and Welfare with regard to all programs under the usual and traditional authority of the Department of Health, Education, and Welfare.

Child care and support services

Appropriations to the Secretary of Health, Education, and Welfare would be authorized for grants and contracts for up to 90 percent of the cost of projects for child care and related services for persons registered under the family assistance plan and in manpower training or employment. The grants would go to any public or nonprofit private agency or organization, and the contracts could be with any public or private agency or organization. The cost of these services could include alteration, remodeling, and renovation of facilities, but no provision is made for wholly new construction. The Secretary of Health, Education, and Welfare could allow the non-Federal share of the cost to be provided in the form of services or facilities.

These provisions (unlike other provisions of the bill) would become effective on enactment of the bill.

Advance funding

To afford adequate notice of available funds, appropriations for 1 year to pay the cost of the program during the next year would be authorized.

Evaluation and research

A continuing evaluation of the program under part C and research for improving it are authorized.

Annual report and Advisory Council

The Secretary of Labor is required to report annually to Congress on the manpower training and related services.

ELIMINATION OF PRESENT PROVISIONS ON CASH ASSISTANCE FOR FAMILIES WITH DEPENDENT CHILDREN

Section 103 of the bill revises part A of title IV of the Social Security Act which relates to cash assistance and services for needy families with children. The new part A is called services to needy families with children, reflecting the elimination of the provisions on cash assistance. The cash assistance part is no longer necessary because of the family assistance plan in the new part D of title IV.

The revised part A provides for continuation of the present program of services for these families. Foster care for children and emergency assistance, as included under existing law, are also continued.

Requirements for State plans

Section 402 of the Social Security Act which sets forth the requirements to be met by State plans before they are approved and qualify the State for Federal financial participation in expenditures, would be revised as appropriate in the light of the elimination of the cash assistance provisions.

Payments to States

The provisions on payments to States for expenditures under approved State plans remain the same as existing law with respect to services, emergency assistance, and foster care. The matching formulas continue to vary, as in existing law, according to the kinds of services involved.

Definitions

The definitions of "family services" and "emergency assistance to needy families with children" have not been substantially changed.

The definitions of "dependent child", "aid to families with dependent children", and "relative with whom any dependent child is living" have been replaced (as no longer applicable) by definitions of—

(1) "child"—which refers to the definition in the new part D, establishing the family assistance plan; this in effect substitutes a requirement that the child be a member of a "family" (as defined in the new part D) instead of having to live with particularly designated relatives;

(2) "needy families with children" (and "assistance to such families")—this being defined as families receiving family assistance benefits under the new part D, if they are also receiving supplementary State payments pursuant to the new part E or would have been eligible for aid under the existing State plan for aid to needy families with children if it had continued in effect.

Foster care and emergency assistance

The provisions on payments for foster care of children and emergency assistance remain virtually the same as under existing law.

Assistance by Internal Revenue Service in locating parents

The provision on this subject remains the same and allows use of the master files of the Internal Revenue Service to locate missing parents in certain cases.

TITLE II—AID TO THE AGED, BLIND, AND DISABLED

This title revises the current title XVI of the Social Security Act and sets forth the revised title XVI in its entirety. One of the major changes is the removal of the provisions relating to medical assistance for the aged which, under existing law, would terminate at the end of calendar 1969. All medical assistance for which the Federal Government shares costs will now be provided under approved title XIX State plans.

Requirements for State plans

Few changes are made in this section (sec. 1602), aside from deleting the provisions relating to medical assistance for the aged. The section retains, without substantial change, the requirements relating to—

- (1) administration by a single State agency (except where a separate agency is permitted for the blind as under existing law);
- (2) financial participation by the State;
- (3) statewideness;

- (4) opportunity for fair hearing;
- (5) methods of administration, including personnel standards, training, and effective use of subprofessional staff;
- (6) reporting to the Secretary as required;
- (7) confidentiality of information relating to recipients;
- (8) opportunity for application and furnishing of assistance with reasonable promptness;
- (9) establishment and maintenance by the State of standards for institutions in which there are individuals receiving aid;
- (10) description of services provided for self-support or self-care; and
- (11) determination of blindness by an ophthalmologist or an optometrist.

The present prohibition against payment to persons in receipt of assistance under title I, IV, X, or XIV would be applicable instead to cases of receipt of family security benefits under the new part D of title IV.

The provision on inclusion of reasonable standards for determining eligibility and amount of aid would be replaced by one requiring a minimum benefit of \$90 per month, less any other income, and by another requiring that the standard of need not be lower than the standard applied under the State plan approved under the existing title XVI or (in case the State had not had such a plan) the appropriate one of the standards of need applied under the plans approved under titles I, X, and XIV.

While the requirement relating to the determination of need and disregarding of certain income in connection therewith has been continued (although without the authorization to disregard \$7.50 per month of any income, in addition to other income which may or must be disregarded), it has been expanded in a manner parallel to family assistance benefits to include disregarding as resources the home, household goods, personal effects, other property which might help to increase the family's ability for self-support, and, finally, any other personal or real property the total value of which does not exceed \$1,500. There would also be a new requirement for not considering the financial responsibility of any other individual for the applicant or recipient unless the applicant is the individual's spouse or child under the age of 21 or blind or severely disabled, and a prohibition against imposition of liens on account of benefits correctly paid to recipients.

Other new requirements relate to provision for the training and effective use of social service personnel, provision of technical assistance to State agencies and local subdivisions furnishing assistance or services, and provision for the development, through research or demonstrations, of new or improved methods of furnishing assistance or services. Also added is a requirement for use of a simplified statement for establishing eligibility and for adequate and effective methods of verification thereof. Finally, there are new requirements for periodic evaluation of the State plan at least annually, with reports thereof being submitted to the Secretary together with any necessary modifications of the State plan; for establishment of advisory committees, including recipients as members; and for observing priorities and performance standards set by the Secretary in the administration of the State plan and in providing services thereunder.

The present prohibitions against any age requirement of more than 65 years and against any citizenship requirement excluding U.S. citizens would be continued.

In place of the present provision on residency, there is a new one which prohibits any residency requirement excluding any resident of the State. Also there would be new prohibitions against any disability or age requirement which excludes a severely disabled individual aged 18 or older, and any blindness or age requirement which excludes any person who is blind (determined under criteria by the Secretary).

Payments

In place of the present provision on the Federal share of expenditures under the approved State plan there is a new formula which provides for payment as follows with respect to expenditures under State plans for aid to the aged, blind, and disabled approved under the new title XVI:

With respect to cash assistance, the Federal Government will pay (1) 100 percent of the first \$50 per recipient, plus (2) 50 percent of the next \$15 per recipient, plus (3) 25 percent of the balance of the payment per recipient which does not exceed the maximum permissible level of assistance per person set by the Secretary (which may be lower in the case of Puerto Rico, the Virgin Islands, and Guam than for other jurisdictions).

With respect to services for which expenditures are made under the approved State plan, the Federal Government would pay the same percentages as are provided under existing law, that is, 75 percent in the case of certain specified services and training of personnel and 50 percent in the case of the remainder of the cost of administration of the State plan.

Payment by Federal Government to individuals

The revised title XVI includes authority for the Secretary to enter into agreements with any State under which the Secretary will make the payments of aid to the aged, blind, and disabled directly to individuals in the State who are eligible therefor. In that case, the State would reimburse the Federal Government for the State's share of those payments and for one-half the additional cost to the Secretary of carrying out the agreement, other than the cost of making the payments themselves.

Definition

The new title XVI defines aid to the aged, blind, and disabled as money payments to needy individuals who are 65 or older or are blind or are severely disabled.

Transitional and related provisions

Titles I, X, and XIV of the Social Security Act would be repealed. Provision is made for making adjustments under the new title XVI on account of overpayments and underpayments under the existing public assistance titles.

Provision is also made for according States a grace period during which they can be eligible to participate in the new title XVI without changing their tests of disability or blindness. The grace period would end for any State with the June 30 following the close of the first

regular session of its State legislature beginning after enactment of the bill.

Conforming amendments

The bill also contains a number of conforming amendments in other provisions of the Social Security Act in order to take account of the substantive changes made by the bill. Thus, the changes in the medic-aid program (title XIX of the Social Security Act) would require the States to cover individuals eligible for supplementary State payments pursuant to the new part E of title IV or who would be eligible for cash assistance under an existing State plan for aid to families with dependent children if it continued in effect and included dependent children of unemployed fathers.

Effective date

The amendments made by the bill would become effective on the first January 1 following the fiscal year in which the bill is enacted. However, if a State is prevented by statute from making the supplementary payments provided for under the new part E of title IV of the Social Security Act, the amendments would not apply to individuals in that State until the first July 1 which follows the end of the State's first regular session of its legislature beginning after the enactment of the bill—unless the State certified before this date that it is no longer prevented by State statute from making the payments. In the latter case the amendments would become effective at the beginning of the first calendar quarter following the certification.

Also, in the case of a State which is prevented by statute from meeting the requirements in the revised section 1602 of the Social Security Act, the amendments made in that title would not apply until the first July 1 following the close of the State's first regular session of its legislature beginning after the enactment of the bill—unless the State submitted before this date a State plan meeting these requirements. In the latter case the amendments would become effective on the date of submission of the plan.

Another exception to this effective date provision is made in the case of the new authorization, in the revised part C of title IV of the Social Security Act, for provision of child care services for persons undergoing training or employment—which would be effective on enactment of the bill.

PROPOSED WELFARE REFORM BILL

A BILL To authorize a family assistance plan providing basic benefits to low-income families with children, to provide incentives for employment and training to improve the capacity for employment of members of such families, to achieve greater uniformity of treatment of recipients under the Federal-State public assistance programs and to otherwise improve such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following Table of Contents, may be cited as the "Family Assistance Act of 1969".

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress hereby finds and declares that—

(1) the present federally assisted welfare program provides benefits which vary widely throughout the country and which are unconscionably low in many States;

(2) the program for needy families with children is often administered in ways which are costly, inefficient, and degrading to personal dignity, and is characterized by intolerable incentives for family breakup, by inadequate encouragements to and opportunities for those on the welfare rolls to enter job training and employment so that they may become self-supporting, and by the inequitable exclusion from assistance of working families in poverty, especially families headed by a male;

(3) the growth of the welfare rolls threatens the fiscal stability of the States and the Federal-State partnership; and

(4) in the light of the harm to individual and family development and well-being caused by lack of income adequate to sustain a decent level of life, and the consequent damage to the human resources of the entire Nation, the Federal Government has a positive interest and responsibility in assuring the correction of these problems.

(b) It is therefore the purpose of this Act to fulfill the responsibility of the Federal Government to expand the training and employment incentives and opportunities, including necessary child care services, for those public assistance recipients who are members of needy families with children and who can become self-supporting; to provide a more adequate level and quality of living through income support and services for dependent persons and families who, through no fault of their own, require public assistance; to provide this financial assistance in a manner designed to strengthen family life and to establish more nearly uniform national standards of eligibility and aid; and to move to greater assumption by the Federal Government of the financial burden of these activities.

TITLE I—FAMILY ASSISTANCE PLAN

ESTABLISHMENT OF FAMILY ASSISTANCE PLAN

SEC. 101. Title IV of the Social Security Act (42 U.S.C. 601, et seq.) is amended by adding after part C the following new parts:

“PART D—FAMILY ASSISTANCE PLAN

“APPROPRIATIONS

“SEC. 441. For the purposes of providing a basic level of financial assistance throughout the Nation to needy families with children, in a manner which will strengthen family life, encourage work training and self-support, and enhance personal dignity, there is authorized to be appropriated for each fiscal year a sum sufficient to carry out this part.

“ELIGIBILITY FOR AND AMOUNT OF FAMILY ASSISTANCE BENEFITS

“Eligibility

“SEC. 442. (a) Each family, as defined in section 445—

“(1) whose income, other than income which is excluded pursuant to section 443, is less than \$500 per year for each of the first 2 members of the family plus \$300 per year for each additional member, and

“(2) whose resources, other than resources excluded pursuant to section 444, are less than \$1,500.

shall, in accordance with and subject to the other provisions of this title, be a paid family assistance benefit.

“Amount

“(b) The family assistance benefit for a family shall be payable at the rate of \$500 per year for each of the first two members of the family plus \$300 per year for each additional member thereof, reduced by the amount of income, not excluded pursuant to section 443, of the members of the family.

“Puerto Rico, the Virgin Islands, and Guam

“(c) For special provisions applicable to Puerto Rico, the Virgin Islands, and Guam, see section 464.

“Period for Determination of Benefits

“(d) (1) A family’s eligibility for and its amount of family assistance benefits shall be determined for each quarter of a calendar year. Such determination shall be made on the basis of the Secretary’s estimate of the family’s income for such quarter, after taking into account income for a preceding period and any modifications in income which are likely to occur on the basis of changes in conditions or circumstances. Eligibility for and the amount of benefits of a family for any quarter shall be redetermined at such time or times as may be provided by the Secretary, such determination to be effective prospectively.

“(2) The Secretary shall by regulation prescribe the cases in which and extent to which the amount of a family assistance benefit for any quarter shall be reduced by reason of the time elapsing since the beginning of such quarter and before the date of filing of the application for the benefit.

“(3) The Secretary may, in accordance with regulations, prescribe the cases in which and the extent to which income received in one period (or expenses incurred in one period in earning income) shall, for purposes of determining eligibility for and amount of family assistance benefits, be considered as received (or incurred) in another period or periods.

“Special Limits on Gross Income

“(e) The Secretary may, in accordance with regulations, prescribe the circumstances under which the gross income from a trade or business (including farming), will be considered sufficiently large to make such family ineligible for such benefits.

“INCOME

“Exclusions from Income

“SEC. 443. (a) In determining the income of a family there shall be excluded—

“(1) subject to limitations (as to amount or otherwise) prescribed by the Secretary, the earned income of each child in the family who is, as determined by the Secretary under regulations, a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment;

“(2) (A) the total unearned income of all members of a family which is, as determined in accordance with criteria prescribed by the Secretary, too inconsequential, or received too infrequently or irregularly, to be included, and (B) subject to limitations prescribed by the Secretary any earned income which, as determined in accordance with such criteria, is received too infrequently or irregularly to be included;

“(3) an amount of earned income of a member of the family equal to all, or such part (and according to such schedule) as the Secretary may prescribe, of the cost incurred by such member for child care which the Secretary deems necessary to securing or continuing in manpower training, vocational rehabilitation, employment, or self-employment.

“(4) the first \$720 per year (or proportionately smaller amounts for shorter periods) of the total of earned income (not excluded by the preceding clauses of this section) of all members of the family plus one-half of the remainder thereof;

“(5) food stamps or any other assistance which is based on need and furnished by any State or political subdivision of a State or any Federal agency or by any private charitable agency or organization (as determined by the Secretary);

“(6) allowances under section 432(a);

"(7) any portion of a scholarship or fellowship received for use in paying the cost of tuition and fees at any educational (including technical or vocational education) institution;

"(8) home produce of a member of the family utilized by the household for its own consumption; and

"(9) one-half of all unearned income (not excluded by the preceding clauses of this subsection) of all members of the family

The preceding provisions of this subsection shall not apply to veterans' pensions or to payments to farmers for price support, diversion, or conservation. For special provisions applicable to Puerto Rico, the Virgin Islands, or Guam, see section 464.

"Meaning of Earned and Unearned Income

"(b) For purposes of this part—

"(1) earned income shall include only—

"(A) remuneration for employment, other than remuneration to which section 209 (b), (c), (d), (f), or (k) applies;

"(B) net earnings from self-employment, as defined in section 211 other than the second and third sentences following clause (C) of subsection (a) (9) and other than clauses (A), (C), and (E) of paragraph (2) and paragraphs (4), (5), and (6), of subsection (c);

"(2) unearned income shall include among other things—

"(A) any payments received as an annuity, pension, retirement, or disability benefit, including veteran's or workmen's compensation and old-age, survivors, and disability insurance, railroad retirement, and unemployment benefits;

"(B) prizes and awards;

"(C) the proceeds of any life insurance policy;

"(D) gifts (cash or otherwise), support and alimony payments, and inheritances; and

"(E) rents, dividends, interest, and royalties.

"RESOURCES

"Exclusions from Resources

"SEC. 444. (a) In determining the resources of a family there shall be excluded:

"(1) the home, household goods, and personal effects;

"(2) other property which, as determined in accordance with and subject to limitations in regulations of the Secretary, is so essential to the family's means of self-support as to warrant its exclusion.

"Disposition of Resources

"(b) The Secretary shall prescribe regulations applicable to the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining the family's eligibility for family assistance benefits. Any portion of the family's benefits paid for such period or periods shall be conditioned on such disposal.

“MEANING OF FAMILY AND CHILD

“Composition of Family

“SEC. 445. (a) Two or more individuals—

“ (1) who are related by blood, marriage, or adoption,

“ (2) who are living in a place of residence maintained by one or more of them as his or her own home,

“ (3) who are residents of the United States, and

“ (4) at least one of whom is a child who is not married to another of such individuals,

shall be regarded as a family for purposes of this part and parts A, C, and E.

“Definition of Child

“(b) For purposes of this part and parts C and E, the term ‘child’ means an individual who is (1) under the age of 18 or (2) under the age of 21 and (as determined by the Secretary under regulations) a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment.

“Members of the Armed Forces

“(c) If an individual is in the Armed Forces of the United States, then, for purposes of determining eligibility for and the amount of family assistance benefits under this part, (1) he shall not be regarded as a member of a family, and (2) the spouse and children of such individual, and such other individuals living in the same place of residence as such spouse and children as may be specified in accordance with regulations of the Secretary, shall not be considered members of a family.

“Determination of Family Relationship

“(d) In determining whether an individual is related by blood, marriage, or adoption, appropriate State law, as determined in accordance with regulations of the Secretary, shall be applied.

“Income and Resources of Noncontributing Adult

“(e) For purposes of determining eligibility for and the amount of family assistance benefits for any family there shall be excluded the income and resources of any individual, other than a child or a parent of a child (or a spouse of a child or parent), which, as determined in accordance with criteria prescribed by the Secretary, is not available to other members of the family; and for such purposes, any such individual shall not be considered a member of such family.

“Recipients of Aid to the Aged, Blind, and Disabled Ineligible

“(f) If any individual is receiving aid to the aged, blind and disabled under a State plan approved under title XVI, or if his needs are taken into account in determining the need of another person receiving such aid, then, for the period for which such aid is received, such individual shall not be regarded as a member of a family for

purposes of determining the amount of the family assistance benefits of the family.

"PAYMENTS AND PROCEDURES

"Payments of Benefits

"SEC. 446. (a) (1) Family assistance benefits shall be paid at such time or times and in such installments as the Secretary determines will best effectuate the purposes of this title.

(2) Payment of the family assistance benefit of any family may be made to any one or more members of the family.

"(3) The Secretary may by regulation establish ranges of incomes within which a single amount of family assistance benefit shall apply.

"Overpayments and Underpayments

"(b) Whenever the Secretary finds that more or less than the correct amount of family assistance benefits has been paid with respect to any family, proper adjustment or recovery shall, subject to the succeeding provisions of this subsection, be made by appropriate adjustments in future payments of the family or by recovery from or payment to any one or more of the individuals who are or were members thereof. The Secretary shall make such provision as he finds appropriate in the case of payment of more than the correct amount of benefits with respect to a family with a view to avoiding penalizing members of the family who were without fault in connection with the overpayment, if adjustment or recovery on account of such overpayment in such case would defeat the purposes of this part, or be against equity or good conscience, or (because of the small amount involved) impede efficient or effective administration of this part.

"Hearings and Review

"(c) (1) The Secretary shall provide reasonable notice and opportunity for a hearing to any individual who is or claims to be a member of a family and is dissatisfied with any determination under this part with respect to eligibility of the family for family assistance benefits, the number of members of the family, or the amount of the benefits.

"(2) Final determination of the Secretary after such hearings shall be subject to judicial review as provided in section 205(g) to the same extent as the Secretary's final determinations under section 205.

"Procedures; Prohibition of Assignments

"(d) The provisions of sections 206 and 207 and subsections (a), (d), (e), and (f) of section 205 shall apply with respect to this part to the same extent as they apply in the case of title II.

"Applications and Furnishing of Information by Families

"(e) (1) The Secretary shall prescribe regulations applicable to families or members thereof with respect to the filing of applications, the furnishing of other data and material, and the reporting of events and changes in circumstances, as may be necessary to determine eligibility for and amount of family assistance benefits.

“(2) In order to encourage prompt reporting of events and changes in circumstances relevant to eligibility for or amount of family assistance benefits, and more accurate estimates of expected income or expenses by members of families for purposes of such eligibility and amount of benefits, the Secretary may prescribe the cases in which and the extent to which—

“(A) failure to so report or delay in so reporting, or

“(B) inaccuracy of information which is furnished by the members and on which the estimates of income or expenses for such purposes are based, will result in treatment as overpayments of all or any portion of payments of such benefits for the period involved.

“Furnishing of Information by Other Agencies

“(f) The head of any Federal agency shall provide such information as the Secretary needs for purposes of determining eligibility for or amount of family assistance benefits, or verifying other information with respect thereto. The Secretary may from time to time pay to the head of such agency, in advance or by way of reimbursement, as may be agreed upon, the cost of providing such information.

“REGISTRATION AND REFERRAL OF FAMILY MEMBERS FOR MANPOWER SERVICES, TRAINING, AND EMPLOYMENT

“SEC. 447. (a) Every individual who is a member of a family which is found to be eligible for family assistance benefits, other than a member to whom the Secretary finds clause (1), (2), (3), (4), (5), or (6) of subsection (b) applies, shall register for manpower services, training, and employment with the local public employment office of the State as provided by regulations of the Secretary of Labor. If and for so long as any such individual is found by the Secretary of Health, Education, and Welfare to have failed (after a reasonable period of time), without good cause as determined by the Secretary of Labor, to so register, he shall not be regarded as a member of a family but his income which would otherwise be counted under this part as income of a family shall be so counted; except that if such individual is the only member of the family other than a child, such individual shall be regarded as a member for purposes of determination of the family's eligibility for family assistance benefits, but not (except for counting his income) for purposes of determination of the amount of such benefits. No part of the family assistance benefits of any such family may be paid to such individual during the period for which the preceding sentence is applicable to him; and the Secretary may, if he deems it appropriate, provide for payment of such benefits during such period to any person, other than a member of such family, who is interested in or concerned with the welfare of the family.

“(b) An individual shall not be required to register pursuant to subsection (a) if the Secretary determines that such individual is:

“(1) ill, incapacitated, or of an advanced age;

“(2) a mother or other relative of a child under the age of 6 who is caring for such child;

"(3) the mother, or other female caretaker of a child, if the father or another adult male relative is in the home and not excluded by clauses (1), (2), (4), or (5) of this subsection;

"(4) a child,

"(5) one whose presence in the home on a substantially continuous basis is required because of the illness or incapacity of another member of the household;

"(6) working full time, as determined in accordance with criteria prescribed by the Secretary of Labor.

An individual who would, but for the preceding sentence, be required to register pursuant to part A, may, if he wishes, register as provided in such subsection.

"(c) The Secretary shall make provision for the furnishing of child care services in such cases and for so long as he deems appropriate in the case of individuals registered pursuant to subsection (a) who are, pursuant to such registration, participating in manpower services, training, or employment.

"(d) In the case of any member of a family receiving family assistance benefits who is not required to register pursuant to subsection (a) because of such member's disability or handicap, the Secretary shall make provision for referral of such member to the appropriate State agency administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act.

"DENIAL OF BENEFITS IN CASE OF REFUSAL OF MANPOWER SERVICES, TRAINING, OR EMPLOYMENT

"SEC. 448. For purposes of determining eligibility for and amount of family assistance benefits under this part, an individual who has registered as required under section 447(a) shall not be regarded as a member of a family, but his income which would otherwise be counted as income of the family under this part shall be so counted, if and for so long as he has been found by the Secretary of Labor, after reasonable notice and opportunity for hearing, to have refused without good cause to participate in suitable manpower services, training, or employment, or to have refused without good cause to accept suitable employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined by the Secretary of Labor, after notification by such employer or otherwise, to be a bona fide offer of employment; except that if such individual is the only member of the family other than a child, such individual shall be regarded as a member of the family for purposes of determination of the family's eligibility for benefits, but not (except for counting his income) for the purposes of determination of the amount of its benefits. No part of the family assistance benefits of any such family may be paid to such individual during the period for which the preceding sentence is applicable to him; and the Secretary may, if he deems it appropriate, provide for payment of such benefits during such period to any person, other than a member of such family, who is interested in or concerned with the welfare of the family.

"TRANSFER OF FUNDS FOR ON-THE-JOB TRAINING PROGRAMS

"SEC. 449. The Secretary shall, pursuant to and to the extent provided by agreement with the Secretary of Labor, pay to the Secretary of Labor amounts which he estimates would be paid as family assistance benefits under this part to individuals participating in public or private employer compensated on-the-job training under a program of the Secretary of Labor if they were not participating in such training. Such amounts shall be available to pay the costs of such programs.

"PART E—STATE SUPPLEMENTATION OF FAMILY ASSISTANCE BENEFITS

"PAYMENTS UNDER TITLES IV, V, XVI, AND XIX CONDITIONED ON
SUPPLEMENTATION

"SEC. 451. In order for a State to be eligible for payments pursuant to title V, XVI, or XIX or, part A or B of this title, with respect to expenditures for any quarter beginning on or after the date this part becomes effective with respect to such State, it must have in effect an agreement with the Secretary under which it will make supplementary payments, as provided in this part, to any family other than a family in which both parents of the child or children are present, neither parent is incapacitated, and the male parent is not unemployed.

"AMOUNT OF SUPPLEMENTARY PAYMENTS

"SEC. 452. (a) Eligibility for and amount of supplementary payments under the agreement with any State under this part shall, subject to the succeeding provisions of this section, be determined by application of the provisions of, and rules and regulations under, section S. 442 (a) (2) and (d), 443, 444, 445, 446 (to the extent the Secretary deems appropriate), 447, and 448, and by application of the standard for determining need under the plan of such State as in effect for July 1969 and complying with the requirements for approval under part A as in effect on such date (but subject to such maximums and percentage reductions as were imposed under such plan on the amount of aid paid and, then, with the resulting amount of the supplementary payment to any individual further reduced by the family assistance benefit payable under part D with respect to him).

"(b) In applying the provisions of section 443 for purposes of supplementary payments pursuant to an agreement under this part—

"(1) in the case of earned income to which clause (4) of subsection (a) of such section 443 applies, the amount to be disregarded shall be \$720 per year (or proportionately smaller amounts for shorter periods), plus—

"(A) one-third of the portion of the remainder of earnings which does not exceed twice the amount of the family assistance benefits that would be payable to the family if it had no income (thereby resulting in reduction of the supplementary payment by one-sixth of that portion of such remainder of the earnings), plus

"(B) one-fifth (or more if the Secretary by regulation so prescribes) of the balance of the earnings (thereby resulting in further reduction of the supplementary payment by four-

fifths, or proportionately less if the Secretary has prescribed such a regulation, of that balance of the earnings) ; and

“(2) in the case of income to which clause (9) of subsection (a) of such section 443 applies, the amount to be disregarded shall be—

“(A) one-third of such income which does not exceed twice the amount of the family assistance benefits that would be payable to the family if it had no income (thereby resulting in reduction of the supplementary payment by one-sixth of that portion of such income), plus

“(B) one-fifth (or more if the Secretary by regulation so prescribes) of the balance of such income (thereby resulting in further reduction of the supplementary payment by four-fifths, or proportionately less if the Secretary has prescribed such a regulation, of that balance of the income) ; and

“(3) the family assistance benefit of a family payable under part D shall not be counted to any extent.

For special provisions applicable to Puerto Rico, the Virgin Islands, and Guam, see section 464.

“(c) The agreement with a State under this part shall—

“(1) provide that it shall be in effect in all political subdivisions of the State;

“(2) provide for the establishment or designation of a single State agency to carry out or supervise the carrying out of the agreement in the State;

“(3) provide for granting an opportunity for a fair hearing before the State agency carrying out the agreement to any individual whose claim for supplementary payments is denied or is not acted upon with reasonable promptness;

“(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the agreement in the State, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients of supplementary payments and other persons of low income, as community services aides, in carrying out the agreement and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants for and recipients of supplementary payments and in assisting any advisory committees established by the State agency;

“(5) provide that the State agency carrying out the agreement will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

“(6) provide safeguards which restrict the use or disclosure of information concerning applicants for and recipients of sup-

plementary payments to purposes directly connected with the administration of this title; and

“(7) provide, that all individuals wishing to make application for supplementary payments shall have opportunity to do so, and that supplementary payments shall be furnished with reasonable promptness to all eligible individuals.

“PAYMENTS TO STATES

“SEC. 453. (a) (1) The Secretary shall pay to any State which has in effect an agreement under this part for any fiscal year in the period ending with the close of the fifth full fiscal year for which this part is effective with respect to such State the excess of—

“(A) (i) the total of its payments for such year pursuant to its agreement under this part which are required under section 452, plus (ii) the difference between (I) the total of the expenditures for such fiscal year under its plan approved under title XVI as aid to the aged, blind, and disabled which would have been included as aid to the aged, blind, or disabled under the plan approved thereunder and in effect for July 1969, plus so much of the rest of such expenditures as are required (as determined by the Secretary) by reason of the amendments to such title made by the Family Assistance Act of 1969 and (II) the total of the amounts determined under section 1604 for such State with respect to such expenditures for such year, over

“(B) 90 per centum of the difference between (i) the total of the expenditures which would have been made as aid or assistance (excluding emergency assistance specified in section 406 (e) (1) (A), foster care under section 408, expenditures for institutional services in intermediate care facilities referred to in section 1121, expenditures for repairs to homes referred to in section 1119, and aid or assistance in the form of medical care or any other type of remedial care) for such year under the plans of such State approved under titles I, IV (part A), X, XIV, and XVI and in effect in the month prior to the enactment of this part if they had continued in effect during such year and if they had included (if they did not already do so) payments to dependent children of unemployed fathers authorized by section 407 (as in effect on July 1, 1969), and (ii) the total of the amounts which would have been determined under sections 3, 403, 1003, 1403, and 1603, or under section 1118, of such State with respect to such expenditures for such year.

The Secretary may prescribe methods for determining the amounts referred to in clause (B) on the basis of estimates and trends in expenditures and other experience of the State for prior years.

“(2) The Secretary shall also pay to each such State an amount equal to 50 per centum of its administrative costs found necessary by the Secretary for carrying out its agreement.

“(b) Payments under subsection (a) shall be made at such time or times, in advance or by way of reimbursement, and in such installments as the Secretary may determine; and shall be made on such conditions as may be necessary to assure the carrying out of the purposes of this title.

"(c) In the case of any State with respect to which the amount determined under clause (A) of subsection (a) (1) for any year is less than 50 per centum of the difference referred to in clause (B) of such subsection for such year, such State shall pay to the Secretary, at such time or times and in such installments as he may prescribe, the sum by which such amount determined under clause (A) of subsection (a) (1) is less than such 50 per centum. If such State does not pay any part of such amount at the time or times prescribed, the Secretary shall withhold such part from sums to which the State is entitled under part A or B of this title or under title V, XVI, or XIX; but the amounts so withheld shall be deemed to have been paid to the State under such part or title. The withholding of amounts pursuant to the preceding sentence shall be effected at such time or times and in such installments as the Secretary may deem appropriate.

"FAILURE BY STATE TO COMPLY WITH AGREEMENT

"SEC. 454. If the Secretary, after reasonable notice and opportunity for hearing to a State with which he has an agreement under this part, finds that such State is failing to comply therewith, he shall withhold all, or such portion as he deems appropriate, of the payments to which such State is otherwise entitled under part A or B of this title or under title V, XVI, or XIX; but the amounts so withheld shall be deemed to have been paid to the State under such part or title. Such withholding shall be effected at such time or times and in such installments as the Secretary may deem appropriate.

"PART F—ADMINISTRATION

"AGREEMENTS WITH STATES

"SEC. 461. (a) The Secretary may enter into an agreement with any State under which the Secretary will make, on behalf of the State, the supplementary payments provided for pursuant to part E or will perform such other functions of the State in connection with such payments as may be agreed upon. In any such case, the agreement shall also provide for payment by the State to the Secretary of an amount equal to the supplementary payments the State would otherwise make under part E, less any payments which would be made to the State under section 453 (a), together with one-half of the additional cost of the Secretary involved in carrying out such agreement, other than the cost of making the payments.

"(b) The Secretary may also enter into an agreement with any State under which such State will make, on behalf of the Secretary, the family assistance benefit payments provided for under part D with respect to all or specified families in the State who are eligible for such benefits or will perform such other functions in connection with the administration of part D as may be agreed upon. The cost of carrying out any such agreement shall be paid to the State in advance or by way of reimbursement and in such installments as may be agreed upon.

"PENALTIES FOR FRAUD

"SEC. 462. The provisions of section 208, other than paragraph (a), shall apply with respect to benefits under part D and allowances

under part C, of this title, to the same extent as they apply to payments under title II.

**"REPORT, EVALUATION, RESEARCH AND DEMONSTRATIONS, AND TRAINING
AND TECHNICAL ASSISTANCE**

"SEC. 463. (a) The Secretary shall make an annual report to the President and the Congress on the operation and administration of parts D and E, including an evaluation thereof in carrying out the purposes of such parts and recommendations with respect thereto. The Secretary is authorized to conduct evaluations directly or by grants or contracts of the programs authorized by such parts.

"(b) The Secretary is authorized to conduct, directly or by grants or contracts, research into or demonstrations of ways of better providing financial assistance to needy persons or of better carrying out the purposes of part D, and in so doing to waive any requirements or limitations in such part with respect to eligibility for or amount of family assistance benefits for such family, members of families, or groups thereof as he deems appropriate.

"(c) The Secretary is authorized to provide such technical assistance to States, and to provide, directly or through grants or contracts, for such training of personnel of States, as he deems appropriate to assist them in more efficiently and effectively carrying out their agreements under this part and part E.

"(d) In addition to funds otherwise available therefor, such portion of any appropriation to carry out part D or E as the Secretary may determine, but not in excess of one-half of 1 per centum thereof, shall be available to him to carry out this section.

"SPECIAL PROVISIONS FOR PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

"SEC. 464. (a) In applying the provisions of sections 442 (a) and (b), 443(a) (4), 452(b) (1), 1603 (a) (1) and (b) (1), and 1604 (1) and (2) with respect to Puerto Rico, the Virgin Islands, or Guam, the amounts to be used shall (instead of the \$500, \$300, and \$1,500 in such section 442 (a) and (b) and section 1603(a) (1), the \$720 in section 443(a) (4) and section 452(b) (1), the \$90 in section 1603(b) (1), the \$65 in section 1604(2), and the \$50 in section 1604(1)) bear the same ratio to such \$500, \$300, \$1,500, \$720, \$90, \$65, and \$50 as the per capita incomes of Puerto Rico, the Virgin Islands, and Guam, respectively, bear to the per capita income of that one of the fifty States which has the lowest per capita income; except that in no case may the amounts so used exceed such \$500, \$300, \$1,500, \$720, \$90, \$65, and \$50.

"(b) (1) The amounts to be used under such sections in Puerto Rico, the Virgin Islands, and Guam shall be promulgated by the Secretary between July 1 and September 30 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the most recent calendar year for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for fiscal year beginning July 1 next succeeding such promulgation: *Provided*, That the Secretary shall promulgate such amounts as soon as possible after the enactment of this part, which promulgation shall be conclusive for six calendar

quarters in the period beginning with the January 1 following the fiscal year in which this part is enacted, and ending with the close of the second June 30 thereafter.

“(2) The term ‘United States’, for purposes of paragraph (1) only, means the fifty States and the District of Columbia.

“(c) If the amounts which would otherwise be promulgated for any year for any of the three States referred to in subsection (a) would be lower than the amounts promulgated for such State for the immediately preceding period, the amounts for such fiscal year shall be increased to the extent of the difference; and the amounts so increased shall be the amounts promulgated for such year.

“MANPOWER SERVICES, TRAINING, EMPLOYMENT, AND CHILD-CARE PROGRAMS

“SEC. 102. Part C of title IV of the Social Security Act (42 U.S.C. 630, et seq.) is amended to read as follows:

“PART C—MANPOWER SERVICES, TRAINING, EMPLOYMENT, AND DAY CARE PROGRAMS FOR RECIPIENTS OF FAMILY ASSISTANCE OR SUPPLEMENTARY BENEFITS

“PURPOSE

“SEC. 430. The purpose of this part is to authorize provision, for individuals who are members of a family receiving benefits under part D or supplementary payments pursuant to part E, of manpower services, training, employment, and child care and related services necessary to train such individuals, prepare them for employment, and otherwise assist them in securing and retaining regular employment and having the opportunity for advancement in employment, to the end that needy families with children will be restored to self-supporting, independent, and useful roles in their communities.

“OPERATION OF MANPOWER SERVICES, TRAINING, AND EMPLOYMENT PROGRAMS

“SEC. 431. (a) The Secretary of Labor (hereinafter in this part referred to as the ‘Secretary’) shall, for each person registered pursuant to part D, in accordance with priorities prescribed by him, develop or assure the development of an employability plan describing the manpower services, training, and employment which the Secretary determines each person needs in order to enable him to become self-supporting and secure and retain employment and opportunities for advancement.

“(b) The Secretary shall, in accordance with the provisions of this part, establish and assure the provision of manpower services, training, and employment programs in each State for persons registered pursuant to part D or receiving supplementary payments pursuant to part E. The Secretary shall, through such programs, provide or assure the provision of manpower services, training, and employment and opportunities necessary to prepare such persons for and place them in regular employment, including such services and opportunities which the Secretary is authorized to provide under any other Act, and including counseling, testing, institutional and on-the-job training, work experi-

ence, up-grading, program orientation, relocation assistance (including grants, loans, and the furnishing of such services as will aid in involuntarily unemployed individual to relocate in an area where he may obtain suitable employment), incentives to public or private employers to hire and train these persons (including reimbursement for a limited period when an employee may not be fully productive), special work projects, job development, coaching, job placement and follow up services required to assist in securing and retaining employment and opportunities for advancement.

"ALLOWANCES FOR INDIVIDUALS UNDERGOING TRAINING

"SEC. 432. (a) (1) The Secretary shall pay to each individual who is a member of a family and is participating in manpower training under this part an incentive allowance of \$30 per month. If such members of a family would (but for the receipt of payments pursuant to this title) be eligible in such month, under any other statute providing for manpower training, for allowances which in total would be in excess of the sum of the family assistance benefit and supplementary payments pursuant to part E payable with respect to such month to the family, the total of the incentive allowances per month under this section for such members shall be equal to such excess, or to \$30 for each such member, whichever is greater.

"(2) The Secretary shall, in accordance with regulations, also pay to any member of a family participating in manpower training under this part, allowances for transportation and other costs to him directly related to his participation in training.

"(3) The Secretary shall by regulation provide for such smaller allowances under this subsection as he deems appropriate for individuals in Puerto Rico, the Virgin Islands, and Guam.

"(b) Such allowances shall be in lieu of allowances provided for participants in manpower training programs under any other Act.

"(c) Subsection (a) shall not apply to any member of a family who is participating in a program of the Secretary providing public or private employer compensated on-the-job training.

"DENIAL OF ALLOWANCES FOR REFUSAL TO UNDERGO TRAINING

"SEC. 433. (a) If and for so long as the Secretary determines that an individual who is a member of a family and has been required to register under part D for manpower training or employment has, without good cause, ceased to participate in manpower training under this part, no allowance under this part shall be payable to such individual.

"(b) The Secretary shall provide reasonable notice and opportunity for hearing to any individual with respect to whom such a determination has been made.

"(c) Final determinations of the Secretary after such hearings shall be subject to judicial review as provided by section 205(g) for final determinations under title II, and the provisions of sections 205 (a), (d), (e), and (f), 206, and 207 shall apply with respect to this part to the same extent as they apply to title II.

"UTILIZATION OF OTHER PROGRAMS

"SEC. 434. In providing the manpower training and employment services and opportunities required by this part the Secretary, to the maximum extent feasible, shall assure that such services and opportunities are provided in such manner, through such means, and using all authority available to him under any other Act (and subject to all duties and responsibilities thereunder) as will further the establishment of an integrated and comprehensive manpower training program involving all sectors of the economy and all levels of government and as will make maximum use of existing manpower and manpower related programs and agencies. To such end the Secretary may use the funds appropriated to him under this part to provide the programs required by this part through such other Act, to the same extent and under the same conditions as if appropriated under such other Act and in making use of the programs of other Federal, State, or local agencies, public or private, the Secretary may reimburse such agencies for services rendered to persons under this part to the extent such services and opportunities are not otherwise available on a nonreimbursable basis.

"RULES AND REGULATIONS

"SEC. 435. The Secretary may issue such rules and regulations as he finds necessary to carry out the purposes of this part: *Provided*, That in developing policies and programs for manpower services, training, and employment, the Secretary shall first obtain the concurrence of the Secretary of Health, Education, and Welfare with regard to such policies and programs which are under the usual and traditional authority of the Secretary of Health, Education, and Welfare (including basic education, institutional training, health, child care and other supportive services, new careers and job restructuring in the health, education, and welfare professions, and work-study programs), and shall consult with the Secretary of Health, Education, and Welfare with regard to all such other policies and programs.

"APPROPRIATIONS

"SEC. 436. There is authorized to be appropriated to the Secretary for each fiscal year a sum sufficient for carrying out the purposes of this part (other than section 437), including payment of not to exceed (except in such cases as the Secretary may determine) 90 per centum of the cost of manpower services, training, and employment and opportunities provided for individuals registered pursuant to section 447. The Secretary of Labor shall establish criteria to achieve an equitable apportionment among the States of Federal expenditures for carrying out the programs authorized by section 431. In developing these criteria the Secretary shall consider the number of registrations under section 447 and other relevant factors.

"CHILD CARE AND SUPPORTIVE SERVICES

"SEC. 437. (a) There are authorized to be appropriated for each fiscal year such sums as may be necessary to enable the Secretary of Health, Education, and Welfare to make grants to any public or nonprofit

private agency or organization, and contracts with any public or private agency or organization, for not to exceed (except in such cases as the Secretary of Health, Education, and Welfare may determine) 90 per centum of the cost of projects for the provision of child care and related services, including necessary alteration, remodeling, and renovation of facilities, which may be necessary or appropriate in order to better enable an individual who has been registered pursuant to part D or is receiving supplementary payments pursuant to part E to undertake or continue manpower training or employment under this part or to enable a member of a family, which is or has been (within such period of time as the Secretary may prescribe) eligible for benefits under such part D or payments pursuant to such part E, to undertake or continue manpower training or employment under this part; or, with respect to the period prior to the date when part D becomes effective for a State, to better enable an individual receiving aid to families with dependent children, or whose needs are taken into account in determining the need of any one claiming or receiving such aid, to participate in manpower training or employment.

“(b) Such sums shall also be available to enable the Secretary of Health, Education, and Welfare to make grants to any public or non-profit private agency or organization, and contracts with any public or private agency or organization for evaluation, training of personnel, technical assistance or research or demonstration projects to determine more effective methods of providing any such care and other services.

“(c) To the extent permitted by the Secretary of Health, Education, and Welfare, the non-Federal share of the cost of any such project may be provided in the form of services or facilities.

“(d) The Secretary of Health, Education, and Welfare may provide, in any case in which a family is able to pay for part or all of the cost of day care or other services provided under a project assisted under this section, for payment by the family of such fees for the care or services as may be reasonable in the light of such ability.

“ADVANCE FUNDING

“SEC. 438. (a) For the purpose of affording adequate notice of funding available under this part, appropriations for grants, contracts, or other payments with respect to individuals registered pursuant to section 447 are authorized to be included in the appropriation Act for the fiscal year preceding the fiscal year for which they are available for obligation.

“(b) In order to effect a transition to the advance funding method of timing appropriation action, the amendment made by subsection (a) shall apply notwithstanding that its initial application will result in enactment in the same year (whether in the same appropriation Act or otherwise) of two separate appropriations, one for the then current fiscal year and one for the succeeding fiscal year.

“EVALUATION AND RESEARCH; REPORT TO CONGRESS

“SEC. 439. (a) The Secretary shall (jointly with the Secretary of Health, Education, and Welfare) provide for the continuing evaluation of the manpower training and employment programs provided under this part, including their effectiveness in achieving stated goals

and their impact on other related programs. The Secretary may conduct research regarding, and demonstrations of, ways to improve the effectiveness of the manpower training and employment programs so provided and may also conduct demonstrations of improved training techniques for upgrading the skills of the working poor. The Secretary may, for these purposes, contract for independent evaluations of and research regarding such programs or individual projects under such programs, and establish a data collection, processing, and retrieval system.

“(b) The Secretary shall report to the Congress on or before the end of each fiscal year (with the first such report being made on or before the July 1 following the first full year after the date on which part D becomes effective with respect to any States) on the manpower training and employment programs provided under this part.”

ELIMINATION OF PRESENT PROVISIONS ON CASH ASSISTANCE FOR FAMILIES
WITH DEPENDENT CHILDREN

SEC. 103. (a) Section 401 of the Social Security Act (42 U.S.C. 601) is amended by striking out “financial assistance and” in the first sentence.

(b) Section 402(a) of such Act (42 U.S.C. 602) is amended by—

(1) striking out “aid and” in so much thereof as precedes clause (1);

(2) inserting, at the beginning of clause (1), “except to the extent permitted by the Secretary,”;

(3) striking out clause (4);

(4) in clause (5) (B), striking out “recipients and other persons” and inserting in lieu thereof “persons” and striking out “providing services to applicants and recipients” and inserting in lieu thereof “providing services under the plan”;

(5) striking out clauses (7) and (8);

(6) in clause (9), striking out “aid to families with dependent children” and inserting in lieu thereof “the plan”;

(7) striking out clauses (10), (11), and (12);

(8) in clause (14), striking out “for each child and relative who receives aid to families with dependent children, and each appropriate individual (living in the same home as a relative and child receiving such aid whose needs are taken into account in making the determination under clause (7))” and inserting in lieu thereof “for each member of a family receiving assistance to needy families with children, each appropriate individual (living in the same home as such family) whose needs would be taken into account in determining the need of any such member under the State plan (approved under this part) as in effect prior to the enactment of part D, and each individual who would have been eligible to receive aid to families with dependent children under such plan” and striking out “such child, relative, and individual” and inserting in lieu thereof “such member or individual”;

(9) striking out clause (15) and inserting in lieu thereof:

“(15) (A) provide for the development of a program, for appropriate members of such families and such other individuals, for preventing

or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases family planning services are offered to them, but acceptance of family planning services provided under the plan shall be voluntary on the part of such members and individuals and shall not be a prerequisite to eligibility for or the receipt of any other service under the plan; and (B) to the extent that services provided under this clause or clause (14) are furnished by the staff of the State agency or the local agency administering the State plan in each of the political subdivisions of the State, for the establishment of a single organizational unit in such State or local agency, as the case may be, responsible for the furnishing of such services;"

(10) striking out "aid" in clause (16) and "aid to families with dependent children" in clause (17) (A) (i) and inserting in lieu thereof "assistance to needy families with children" and striking out "aid" in clause (17) (A) (ii) and inserting in lieu thereof "assistance";

(11) striking out clause (19);

(12) striking out "aid to families with dependent children in the form of foster care" in clause (20) and inserting in lieu thereof "payments for foster care"; striking out "dependent child or children with respect to whom aid is being provided under the State plan" in clause (21) (A) and inserting in lieu thereof "child or children with respect to whom assistance to needy families with children or foster care is being provided";

(13) striking out "aid is being provided under the plan of such other State" in clause (A) and clause (B) of clause (22) and inserting in lieu thereof "assistance to needy families with children or foster care payments are being provided in such other State";

(14) striking out clause (23) and striking out "; and" at the end of clause (22) and inserting in lieu thereof a period.

(c) Section 402(b) of such Act is amended to read as follows:

"(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for services under it, a residence requirement which denies services or foster care payments with respect to any individual residing in the State.

(d) Such section 402 is further amended by striking out subsection (c) thereof.

(e) Subsection (a) of section 403 of such Act (42 U.S.C. 603) is amended by—

(1) striking out "aid and services" and inserting in lieu thereof "services" in so much thereof as precedes paragraph (1);

(2) amending paragraph (1) to read:

"(1) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as payments for foster care in accordance with section 408—

"(A) five-sixths of such expenditures, not counting so much of any expenditures as exceeds the product of \$18 multiplied by the number of children receiving such foster care in such month; plus

"(B) the Federal percentage of the amount by which such

expenditures exceeds the maximum which may be counted under subparagraph (A), not counting so much of any expenditures with respect to such month as exceeds the product of \$100 multiplied by the number of children receiving such foster care for such month."

(3) striking out paragraph (2) ;

(4) in paragraph (3), striking out "in the case of any State," in so much thereof as precedes subparagraph (A), striking out in clause (i) of such subparagraph "or relative who is receiving aid under the plan, or to any other individual (living in the same home as such relative and child) whose needs are taken into account in making the determination under clause (7) of such section" and inserting in lieu thereof "receiving foster care or any member of a family receiving assistance to needy families with children or to any other individual (living in the same home as such family) whose needs would be taken into account in determining the need of any such member under the State plan approved under this part as in effect prior to the enactment of part D, striking out in clause (ii) of such subparagraph "child or relative who is applying for aid to families with dependent children or" and inserting in lieu thereof "member of a family" and striking out in such clause (ii) "likely to become an applicant for or recipient of such aid" and inserting in lieu thereof "likely to become eligible to receive such assistance";

(5) striking out the sentences of such subsection (a) which follow paragraph (5) ;

(f) Subsection (b) of such section 403 is amended by striking out "records showing the number of dependent children in the State and (C)" in paragraph (1) thereof and by striking out, in paragraph (2) thereof, "(A)" and everything beginning with ", and (B)" and all that follows down to but not including the period.

(g) Section 404 of such Act (42 U.S.C. 604) is amended by striking out "(a) In the case of any State plan for aid and services" and inserting in lieu thereof "In the case of any State plan for services" and by striking out subsection (b) thereof.

(h) Section 405 of such Act (42 U.S.C. 605) is repealed.

(i) Section 406 of such Act (42 U.S.C. 606) is amended by—

(1) striking out subsections (a) and (b) and inserting in lieu thereof:

"(a) The term 'child' means a child as defined in section 445(b).

"(b) The term 'needy families with children' means families who are receiving family assistance benefits under part D and who (1) are receiving supplementary payments under part E, or (2) would be eligible to receive aid to families with dependent children, under a State plan (approved under this part) as in effect prior to the enactment of part D, if the State plan had continued in effect and if it included assistance to dependent children of unemployed fathers pursuant to section 407 as it was in effect prior to such enactment; and 'assistance to needy families with children' means family assistance benefits under such part D, paid to such families."

(2) striking out subsection (c) ;

(3) in subsection (e) (1), striking out "living with any of the relatives specified in subsection (a) (1) in a place of residence

maintained by one or more of such relatives as his or their own home" and inserting in lieu thereof "a member of a family (as defined in section 445(a))" and striking out "because such child or relative refused" and inserting in lieu thereof "because such child or another member of such family refused."

(j) Section 407 of such Act (42 U.S.C. 607) is repealed.

(k) Section 408 of such Act (42 U.S.C. 608) is amended by—

(1) amending so much (including the heading) thereof as preceeds subparagraph (1) of paragraph (b) to read as follows:

"FOSTER CARE

"SEC. 408. For purposes of this part—

"(a) Foster care shall include only such care which is provided in behalf of a child (1) who would, except for his removal from the home of a family as a result of a judicial determination to the effect that continuation therein would be contrary to his welfare, be a member of such family receiving assistance to needy families with children, (2) whose placement and care are the responsibility of (A) the State or local agency administering the State plan approved under section 402, or (B) any other public agency with whom the State agency administering or supervising the administration of such State plan has made an agreement which is still in effect and which includes provision for assuring development of a plan, satisfactory to such State agency, for such child as provided in paragraph (f)(1) and such other provisions as may be necessary to assure accomplishment of the objectives of the State plan approved under section 402, (3) who has been placed in a foster family home or child-care institution as a result of such determination, and (4) who (A) received assistance to needy families with children in or for the month in which court proceedings leading to such determination were initiated, or (B) would have received such assistance to needy families with children in or for such month if application had been made therefore, or (C) in the case of a child who had been a member of a family (as defined in section 445(a)) within 6 months prior to the month in which such proceedings were initiated, would have received such assistance in or for such month if in such month he had been a member of (and removed from the home of) such a family and application had been made therefor;

"(b) but only if such care is provided—";

(2) in paragraph (b)(2), striking out "aid to families with dependent children" and inserting in lieu thereof "foster care" and striking out "such foster care" and inserting in lieu thereof "foster care";

(3) striking out subsection (c);

(4) striking out "aid" and inserting in lieu thereof "services" in subsection (e);

(5) in subsection (f)(1), striking out "relative specified in section 406(a)" and inserting in lieu thereof "family (as defined in section 445(a))";

(6) in subsection (f)(2), striking out "522" and inserting in lieu thereof "422" and striking out "part 3 of title V" and inserting in lieu thereof "part B of this title".

CHANGE IN HEADING

SEC. 104. (a) The heading of title IV of the Social Security Act (42 U.S.C. 601, et seq.) is amended to read as follows:

"TITLE IV—FAMILY ASSISTANCE BENEFITS, STATE SUPPLEMENTAL PAYMENTS, WORK INCENTIVE PROGRAMS, AND GRANTS TO STATES FOR FAMILY AND CHILD WELFARE SERVICES"

(b) The heading of part A of such title IV is amended to read as follows:

"PART A—SERVICES TO NEEDY FAMILIES WITH CHILDREN"

TITLE II—AID TO THE AGED, BLIND, AND DISABLED

GRANTS TO STATES FOR AID TO THE AGED, BLIND, AND DISABLED

SEC. 201. Title XVI of the Social Security Act (42 U.S.C. 1381 et seq.) is amended to read as follows:

"TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, AND DISABLED

"APPROPRIATIONS

"SEC. 1601. For the purpose of enabling each State to furnish financial assistance to needy individuals who are 65 years of age or over, blind, or disabled and for the purpose of encouraging each State to furnish rehabilitation and other services to help such individuals attain or retain capability for self-support or self-care, there are authorized to be appropriated for each fiscal year sums sufficient to carry out these purposes. The sums made available under this section shall be used for making payments to States having State plans approved under section 1602.

"STATE PLANS FOR FINANCIAL ASSISTANCE AND SERVICES TO THE AGED, BLIND, AND DISABLED

"SEC. 1602. (a) A State plan for aid to the aged, blind, and disabled must—

"(1) provide for the establishment or designation of a single State agency to administer or supervise the administration of the State plan;

"(2) provide such methods of administration as are found by the Secretary to be necessary, for the proper and efficient operation of the plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (but the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of individuals employed in accordance with such methods);

"(3) provide for the training and effective use of social service personnel in the administration of the plan, for the furnishing of technical assistance to units of State government and of po-

litical subdivisions which are furnishing financial assistance or services to the aged, blind, and disabled, and for the development through research or demonstration projects of new or improved methods of furnishing assistance or services to the aged, blind, and disabled;

"(4) provide for the training and effective use of paid sub-professional staff (with particular emphasis on the full-time or part-time employment of recipients and other persons of low-income as community service aides) in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

"(5) provide that all individuals wishing to make application for aid under the plan shall have opportunity to do so and that such aid shall be furnished with reasonable promptness with respect to all eligible individuals;

"(6) provide for the use of a simplified statement, conforming to standards prescribed by the Secretary, to establish eligibility, and for adequate and effective methods of verification of eligibility of applicants and recipients through the use, in accordance with regulations prescribed by the Secretary, of sampling and other scientific techniques;

"(7) provide that, except to the extent permitted by the Secretary with respect to services, the State plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

"(8) provide for financial participation by the State;

"(9) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

"(10) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid under the plan is denied or is not acted upon with reasonable promptness;

"(11) provide for periodic evaluation of the operations of the State plan, not less often than annually, in accordance with standards prescribed by the Secretary, and the furnishing of annual reports of such evaluations to the Secretary together with any necessary modifications of the State plan resulting from such evaluations;

"(12) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

"(13) provide safeguards which restrict the use of disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan (consistent with section 618 of the Revenue Act of 1951);

"(14) provide, if the plan includes aid to or on behalf of individuals in private or public institutions, for the establish-

ment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

“(15) provide a description of the services which the State makes available to applicants for or recipients of aid under the plan to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of all available services that are similar or related;

“(16) provide for periodic evaluation of the operation of the plan by persons interested in or expert in matters related to assistance and services to the aged, blind, and disabled, including persons who are recipients of aid to the aged, blind, and disabled; and

“(17) assure that, in administering the State plan and providing services thereunder, the State will observe priorities established by the Secretary and comply with such performance standards as the Secretary may, from time to time, establish.

Notwithstanding paragraph (1), if on January 1, 1962, and on the date on which a State submits (or submitted) its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approval under title X was different from the State agency which administered or supervised the administration of the plan of such State approved under title I and the State agency which administered or supervised the administration of the plan of such State approved under title XIV, then the State agency which administered or supervised the administration of such plan approved under title X may be designated to administer or supervise the administration of the portion of the State plan for aid to the aged, blind, and disabled which relates to blind individuals and a separate State agency may be established or designated to administer or supervise the administration of the rest of such plan; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title.

“(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) and in section 1603, except that he shall not approve any plan which imposes, as a condition of eligibility for aid under the plan—

“(1) an age requirement of more than sixty-five years;

“(2) any residency requirement which excludes any individual who resides in the State;

“(3) any citizen requirement which excludes any citizen of the United States;

“(4) any disability or age requirement which excludes any persons under a severe disability, as determined in accordance with criteria prescribed by the Secretary, who are eighteen years of age or older; or

“(5) any blindness or age requirement which excludes any persons who are blind as determined in accordance with criteria prescribed by the Secretary.

In the case of any State to which the provisions of section 344 of the Social Security Act Amendments of 1950 were applicable on Janu-

ary 1, 1962, and to which the sentence of section 1002(b) following paragraph (2) thereof is applicable on the date on which its State plan was or is submitted for approval under this title, the Secretary shall approve the plan of such State for aid to the aged, blind, and disabled for purposes of this title, even though it does not meet the requirements of section 1603(a) if it meets all other requirements of this title for an approved plan for aid to the aged, blind, and disabled; but payments to the State under this title shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of this title under a plan approved under this section without regard to the provisions of this sentence.

"DETERMINATION OF NEED

"SEC. 1603. (a) A State plan must provide that, in determining the need for aid under the plan, the State agency shall take into consideration any other income or resources of the individual claiming such aid as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination with respect to any individual—

"(1) the State agency shall not consider as resources (A) the home, household goods, and personal effects of the individual, (B) other personal or real property, the total value of which does not exceed \$1,500, or (C) other property which as determined in accordance with and subject to limitations in regulations of the Secretary, is so essential to the family's means of self-support as to warrant its exclusion, but shall apply the provisions of section 442(e) and regulations thereunder;

"(2) the State agency shall not consider the financial responsibility of any individual for any applicant or recipient unless the applicant or recipient is the individual's spouse, or the individual's child who is under the age of 21 or is blind or severely disabled;

"(3) if such individual is blind, the State agency (A) shall disregard the first \$85 per month of earned income plus one-half of earned income in excess of \$85 per month, and (B) shall, for a period not in excess of twelve months, and may, for a period not in excess of thirty-six months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan;

"(4) if the individual is not blind but is severely disabled, the State agency may disregard (A) not more than the first \$20 of the first \$80 per month of earned income plus one-half of the remainder thereof and (B) such additional amounts of other income and resources, for a period not in excess of thirty-six months, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of the plan, but only with respect to the part or parts of such period during substantially all of which he is undergoing vocational rehabilitation;

"(5) if such individual has attained age 65 and is neither blind nor severely disabled, the State agency may disregard not more

than the first \$20 of the first \$80 per month of earned income plus one-half of the remainder thereof.

“(b) A State plan must also provide that—

“(1) each eligible individual, other than one who is a patient in a medical institution or is receiving institutional services in an intermediate care facility to which section 1121 applies, shall receive financial assistance in such amount as, when added to his income which is not disregarded pursuant to subsection (a), will provide a minimum of \$90 per month.

“(2) the standard of need applied for determining eligibility for an amount of aid for the aged, blind, and disabled shall not be lower than (A) the standard applied for this purpose under the State plan (approved under this title) as in effect on the date of enactment of part D of title IV of this Act, or (B) if there was no such plan in effect for such State on such date, the standard of need which was applicable under

“(i) the State plan which was in effect on such date and was approved under title I, in the case of any individual who is 65 years of age or older,

“(ii) the State plan in effect on such date and approved under title X, in the case of an individual who is blind, or

“(iii) the State plan in effect on such date and approved under title XIV, in the case of an individual who is severely disabled.

except that if 2 or more of clauses (i), (ii), and (iii) are applicable to an individual, the standard of need applied with respect to such individual may not be lower than the higher (or highest) of the standards under the applicable plans, and except that if none of such clauses is applicable to individuals, the standard of need applied with respect to such individual may not be lower than higher of the standards under the State plans approved under title I, X, or XIV, which was in effect on such date, and

“(3) no aid will be furnished to any individual under the State plan for any period with respect to which he is considered a member of a family receiving family assistance benefits under part D of title IV or training allowances under part C thereof for purposes of determining the amount of such benefits or allowances (but this paragraph shall not prevent payments with respect to other members of his family pursuant to title IV of this Act).

“(4) no lien will be imposed against the property of any individual or his estate on account of aid paid to him under the plan (except pursuant to the judgement of a court on account of benefits incorrectly paid to such individual), and that there will be no adjustment or any recovery of aid correctly paid to him under the plan.

“(c) For special provisions applicable to Puerto Rico, the Virgin Islands, and Guam, see section 464.

“PAYMENTS TO STATES FOR AID TO THE AGED, BLIND, AND DISABLED

“SEC. 1604. From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each calendar quarter, an amount equal to the sum of the following

proportions of the total amounts expended during each month of such quarter as aid to the aged, blind, and disabled under the State plan—

“(1) 100 per centum of such expenditures, not counting so much of any expenditures as exceeds the product of \$50 multiplied by the total number of recipients of such aid for such month; plus

“(2) 50 per centum of the amount by which such expenditures exceed the maximum which may be counted under paragraph (1), not counting so much of any expenditures with respect to such month as exceeds the product of \$65 multiplied by the total number of recipients of such aid for such month; plus

“(3) 25 per centum of the amount by which such expenditures exceed the maximum which may be counted under paragraph (2), not counting so much of any expenditures with respect to such month as exceeds the product of the amount which, as determined by the Secretary, is the maximum permissible level of assistance per person in which the Federal Government will participate financially, multiplied by the total number of recipients of such aid for such month.

In the case of any individual in Puerto Rico, the Virgin Islands, or Guam, the maximum permissible level of assistance under paragraph (3) may be lower than in the case of individuals in the other States. See also, section 464 for other special provisions applicable to Puerto Rico, the Virgin Islands, and Guam.

“ALTERNATE PROVISION FOR DIRECT FEDERAL PAYMENTS TO INDIVIDUALS

“SEC. 1605. The Secretary may enter into an agreement with a State under which he will, on behalf of the State, pay aid to the aged, blind, and disabled directly to individuals in the State under the State's plan approved under this title and perform such other functions of the State in connection with such payments as may be agreed upon. In such case payments shall not be made as provided in section 1604 and the agreement shall also provide for payment to the Secretary by the State of its share of such aid, together with one-half of the additional cost to the Secretary involved in carrying out the agreement, other than the cost of making the payments.

“OVERPAYMENTS AND UNDERPAYMENTS

“SEC. 1606. Whenever the Secretary finds that more or less than the correct amount of payment has been made to any person as a direct Federal payment pursuant to section 1605, proper adjustment or recovery shall, subject to the succeeding provisions of this section, be made by appropriate adjustments in future payments of the overpaid individual or by recovery from him or his estate or payment to him. The Secretary shall make such provision as he finds appropriate in the case of payment of more than the correct amount of benefits with a view to avoiding penalizing individuals who were without fault in connection with the overpayment, if adjustment or recovery on account of such overpayment in such case would defeat the purposes of this title, or be against equity or good conscience, or (because of the small amount involved) impede efficient or effective administration.

“OPERATION OF STATE PLANS

“SEC. 1607. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

“(1) that the plan no longer complies with the provisions of sections 1602 or 1603; or

“(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that all, or such portion as he deems appropriate, of any further payments will not be made to the State or individuals within the State under this title (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no such further payments to the State or individuals in the State under this title (or shall limit payments to categories under or parts of the State plan not affected by such failure).

“PAYMENTS TO STATES FOR SERVICES AND ADMINISTRATION

“SEC. 1608. (a) If the State plan of a State approved under section 1602 provides that the State agency will make available to applicants for or recipients of aid to the aged, blind, and disabled under the State plan at least those services to help them attain or retain capability for self-support or self-care which are prescribed by the Secretary, such State shall qualify for payments for services under subsection (b) of this section.

“(b) In the case of any State whose State plan approved under section 1602 meets the requirements of subsection (a), the Secretary shall pay to the State from the sums appropriated therefor an amount equal to the sum of the following proportions of the total amounts expended during each quarter, as found necessary by the Secretary for the proper and efficient administration of the State plan—

“(1) 75 per centum of so much of such expenditures as are for—

“(A) services which are prescribed pursuant to subsection (a) and are provided (in accordance with subsection (c)) to applicants for or recipients of aid under the plan to help them attain or retain capability for self-support or self-care, or

“(B) other services, specified by the Secretary as likely to prevent or reduce dependency, so provided to the applicants or recipients of aid, or

“(C) any of the services prescribed pursuant to subsection (a), and any of the services specified in subparagraph (B) of this paragraph, which the Secretary may specify as appropriate for individuals who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of aid under the plan, if such services are requested by the individuals and are provided to them in accordance with subsection (c), or

“(D) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

“(2) one-half of so much of such expenditures (not included under paragraph (1)) as are for services provided (in accordance with subsection (c)) to applicants for or recipients of aid under the plan, and to individuals requesting such services who (within such period or periods as the Secretary may prescribe) have been or are likely to become applicants for or recipients of such aid; plus

“(3) one-half of the remainder of such expenditures.

“(c) The services referred to in paragraphs (1) and (2) of subsection (b) shall, except to the extent specified by the Secretary, include only—

“(1) services provided by the staff of the State agency, or the local agency administering the State plan in the political subdivision (but no funds authorized under this title shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (A) which are available to individuals in need of them under programs for their rehabilitation carried on under a State plan approved under that Act, or (B) which the State agency or agencies administering or supervising the administration of the State plan approved under that Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under paragraph (2), if provided by such staff), and

“(2) subject to limitations prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of that State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies).

Services described in clause (B) of paragraph (1) may be provided only pursuant to agreement with the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act.

“(d) The portion of the amount expended for administration of the State plan to which paragraph (1) of subsection (b) applies and the portion thereof to which paragraphs (2) and (3) of subsection (b) apply shall be determined in accordance with such methods and procedures as may be permitted by the Secretary.

“(e) In the case of any State whose plan approved under section 1602 does not meet the requirements of subsection (a) of this section, there shall be paid to the State, in lieu of the amount provided for under subsection (b), an amount equal to one-half the total of the sums expended during each quarter as found necessary by the Secre-

tary for the proper and efficient administration of the State plan, including services referred to in subsections (b) and (c) and provided in accordance with the provisions of those subsections.

“(f) In the case of any State whose State plan included a provision meeting the requirements of subsection (a), but with respect to which the Secretary finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the plan, that—

“(1) the provision no longer complies with the requirements of subsection (a), or

“(2) in the administration of the plan there is a failure to comply substantially with such provision,

the Secretary shall notify the State agency that all, or such portion as he deems appropriate, of any further payments will not be made to the State under subsection (b) until he is satisfied that there will no longer be any such failure to comply. Until the Secretary is so satisfied, no such further payments with respect to the administration of and services under the State plan shall be made, subject to the other provisions of this title, under subsection (e) instead of subsection (b).

“COMPUTATION OF PAYMENTS TO STATES

“SEC. 1609. (a) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections 1604 and 1608 for that quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in that quarter in accordance with the provisions of sections 1604 and 1608, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in that quarter, and, if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

“(2) The Secretary shall then pay in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to the State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

“(b) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by a State or political subdivision thereof with respect to aid furnished under the State plan, but excluding any amount of such aid recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased, shall be considered an overpayment to be adjusted under subsection (a) (2).

“(c) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

"DEFINITION

"SEC. 1610. For purposes of this title, the term 'aid to the aged, blind, and disabled' means money payments to needy individuals who are 65 years of age or older, are blind, or are severely disabled, but such term does not include—

"(1) any such payments to any individual who is an inmate of a public institution (except as a patient in a medical institution); or

"(2) any such payments to any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1602 includes provision for—

"(A) determination by the State agency that the needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

"(B) making such payments only in cases in which the payment will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the aged, blind, and disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

"(C) undertaking and continuing special efforts to protect the welfare of such individuals and to improve, to the extent possible, his capacity of self-care and to manage funds;

"(D) periodic review by the State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of the payments if they do not and for seeking judicial appointment of a guardian, or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of the needy individual; and

"(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made.

Whether an individual is blind or severely disabled, shall be determined for purposes of this title in accordance with criteria prescribed by the Secretary."

REPEAL OF TITLES I, X, AND XIV OF THE SOCIAL SECURITY ACT

SEC. 202. Titles I, X, and XIV of the Social Security Act (42 U.S.C. 301, et seq., 1201, et seq., 1351, et seq.) are hereby repealed.

TRANSITION PROVISION RELATING TO OVERPAYMENTS AND UNDERPAYMENTS

SEC. 203. In the case of any State which has a State plan approved under title I, X, XIV, or XVI of the Social Security Act as in effect prior to the enactment of this section, any overpayment or underpayment which the Secretary determines was made to such State under section 3, 1003, 1403, or 1603 of such Act with respect to a period before the approval of a plan under title XVI as amended by this Act, and with respect to which adjustment has not already been made under subsection (b) of such section 3, 1003, 1403, or 1603, shall, for purposes of section 1609(a) of such Act as herein amended be considered an overpayment or underpayment (as the case may be) made under title XVI of such Act as herein amended.

TRANSITION PROVISION RELATING TO DEFINITIONS OF BLINDNESS
AND DISABILITY

SEC. 204. In the case of any State which has in operation a plan of aid to the blind under title X, aid to the permanently and totally disabled under title XIV, or aid to the aged, blind, or disabled under title XVI, of the Social Security Act as in effect prior to the enactment of this Act, the State plan of such State submitted under title XVI of such Act as amended by this Act shall not be denied approval thereunder, with respect to the period ending with the first July 1 which follows the close of the first regular session of the legislature of such State which begins after the enactment of this Act, by reason of its failure to include therein a test of disability or blindness different from that included in the State's plan (approved under such title X, XIV, or XVI of such Act) as in effect on the date of the enactment of this Act.

TITLE III—MISCELLANEOUS CONFORMING
AMENDMENTS

SEC. 301. Section 228(d) (1) of the Social Security Act is amended by striking out "I, X, XIV, or" and by striking out "part A" and inserting in lieu thereof "receives payments with respect to such month pursuant to part D or E".

SEC. 302. Title XI of the Social Security Act is amended as follows:

(1) in section 1101(a) (1) by striking out "I," "X," and "XIV,";

(2) in section 1106(c) (1) (A) by striking out "I, X, XIV,";

(3) in section 1108 by striking out "I, X, XIV, and XVI" and inserting in lieu thereof "XVI" in subsection (a) and by striking out "section 402(a) (19)" and inserting in lieu thereof "part A of title IV" in subsection (b);

(4) by amending section 1109 to read as follows:

"SEC. 1109. Any amount which is disregarded (or set aside for future needs) in determining the eligibility for and amount of aid or assistance for any individual under a State plan approved under title XVI or XIX, or eligibility for and amount of payments pursuant to part D or E of title IV, shall not be taken into consideration in determining the eligibility for and amount of such aid, assistance, or

payments for any other individual under such other State plan or such part D or E.”;

(5) in section 1111 by striking out “I, X, XIV, and” and by striking out “part A” and inserting in lieu thereof “parts D and E”;

(6) in section 1115 by striking out “I, X, XIV,” and by striking out “part A” and inserting in lieu thereof “parts A and E” in so much thereof as precedes clause (a), by striking out “of section 2, 402, 1002, 1402,” and inserting in lieu thereof “of or pursuant to section 402, 452,” in clause (a) thereof, and by striking out “3, 403, 1003, 1403, 1603,” and inserting in lieu thereof “403, 453, 1604, 1608,” in clause (b) thereof;

(7) in section 1116 by striking out “I, X, XIV,” in subsections (a) (1), (b), and (d), and by striking out “4, 404, 1004, 1404, 1604,” in subsection (a) (3) and inserting in lieu thereof “404, 1608,”;

(8) by repealing section 1118;

(9) in section 1119 by striking out “I, X, XIV,” and by striking out “part A” and inserting in lieu thereof “services under a State plan approved under part A”, and by striking out “3(a), 403(a), 1003(a), 1403(a), or 1603(a)” and inserting in lieu thereof “403 (a) or 1604”;

(10) in section 1121(a) by striking out “a plan for old-age assistance, approved under title I, a plan for aid to the blind, approved under title X, a plan for aid to the permanently and totally disabled, approved under title XIV, or a plan for aid to the aged, blind, or disabled” and inserting in lieu thereof “a plan for aid to the aged, blind, and disabled”, and by inserting “(other than a public nonmedical facility)” after “intermediate care facilities” the first time it appears therein.

SEC. 303. Title XVIII of the Social Security Act is amended as follows:

(1) in section 1843(b) by striking out “title I or” in paragraph (1), by striking out “all of the plans” in paragraph (2) and substituting in lieu thereof “the plan”, and by striking out “titles I, X, XIV, and XVI, and part A” in paragraph (2) and inserting in lieu thereof “title XVI and under part E”;

(2) in section 1843(f) by striking out “title I, X, XIV, or XVI or part A” both times it appears and inserting in lieu thereof “title XVI and under part E”, and by striking out “title I, XVI, or XIX” and inserting in lieu thereof “title XVI or XIX”;

(3) in section 1863 by striking out “I, XVI”, and inserting in lieu thereof “XVI”.

SEC. 304. Title XIX of the Social Security Act is amended as follows:

(1) in clause (1) of the first sentence of section 1901 by striking out “families with dependent children” and “permanently and totally” and inserting in lieu thereof, respectively, “needy families with children” and “severely”;

(2) in section 1902(a) (5) by striking out “I or”;

(3) in section 1902(a) (10) by amending so much thereof as precedes clause (A) to read:

“(10) provide for making medical assistance available to all individuals receiving assistance to needy families with children as defined in section 406(b), receiving payments under an agreement pursuant to part E of title IV, or receiving aid to the aged, blind, and disabled under a State plan approved under title XVI; and—”

and by amending clauses (A) and (B) by inserting “or payments under such part E” after “such plan” each time it appears therein;

(4) by amending section 1902(a)(13)(B) to read:

“(B) in the case of individuals receiving assistance to needy families with children as defined in section 406(b), receiving payments under an agreement pursuant to part E of title IV, or receiving aid to the aged, blind, and disabled under a State plan approved under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and”;

(5) in section 1902(a)(14)(A) by striking out “aid or assistance under State plans approved under title I, X, XIV, XVI, and part A of title IV,” and inserting in lieu thereof “assistance to needy families with children as defined in section 406(b), receiving payments under an agreement pursuant to part E of title IV, or receiving aid to the aged, blind, and disabled under a State plan approved under title XVI,”;

(6) in section 1902(a)(17) by striking out in so much thereof as precedes clause (A) “aid or assistance under the State’s plan approved under title I, X, XIV, or XVI, or part A of title IV,” and inserting in lieu thereof “assistance to needy families with children as defined in section 406(b), payments under an agreement pursuant to part E of title IV, or aid under a State plan approved under title XVI,” by striking out in clause (B) thereof “aid or assistance in the form of money payments under a State plan approved under title I, X, XIV, or XVI, or part A of title IV” and inserting in lieu thereof “assistance to needy families with children as defined in section 406(b), payments under an agreement pursuant to part E of title IV, or aid to the aged, blind, and disabled under a State plan approved under title XVI”, and by striking out in such clause (B) “and or assistance under such plan” and inserting in lieu thereof “assistance, and, or payments”;

(7) in section 1902(a)(20)(C) by striking out “section 3(a)(4)(A)(i) and (ii) or section 1603(a)(4)(A)(i) and (ii)” and inserting in lieu thereof “section 1608(b)(1)(A) and (B)”;

(8) in the last sentence of section 1902(a) by striking out “title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind)” and inserting in lieu thereof, “title XVI, insofar as it relates to the blind, was different from the agency which administered or supervised the administration of such plan insofar as it relates to the aged, the agency which administered or supervised the administration of the plan insofar as it relates to the blind”;

(9) in section 1902(b) (2) by striking out “section 406(a) (2)” and inserting in lieu thereof “section 406(b)”;

(10) in section 1902(c) by striking out “I, X, XIV, or XVI, or part A” and inserting in lieu thereof “XVI or under an agreement under part E”;

(11) in section 1903(a) (1) by striking out “I, X, XIV, or XVI, or part A” and inserting in lieu thereof “XVI or under an agreement under part E”;

(12) by repealing subsection (c) of section 1903;

(13) in section 1903(f) (1) (B) (i) by striking out “highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act” and inserting in lieu thereof, “highest total amount which would ordinarily be paid under parts D and E of title IV to a family of the same size without income or resources, eligible in that State for money payments under part E of title IV of this Act”;

(14) in section 1903(f) (3) by striking out “the ‘highest amount which would ordinarily be paid’ to such family under the State’s plan approved under part A of title IV of this Act” and inserting in lieu thereof “the ‘highest total amount which would ordinarily be paid’ to such family”;

(15) in section 1903(f) (4) (A) by striking out “I, X, XIV, or XVI, of part A” and inserting in lieu thereof “XVI or under an agreement under part E”; and

(16) by amending section 1905(a)—

(A) by striking out “aid or assistance under the State’s plan approved under title I, X, XIV, or XVI, or part A of title IV who are—” in so much thereof as precedes clause (i) and inserting in lieu thereof “payments under part E of title IV or aid under a State plan approved under title XVI, who are—”,

(B) by amending clause (ii) to read: “(ii) receiving assistance to needy families with children as defined in section 406(b), or payments pursuant to an agreement under part E of title IV,”

(C) by amending clause (v) to read: “(v) severely disabled as defined by the Secretary in accordance with section 1602(b) (4),” and

(D) by striking out “or assistance” and “I, X, XIV, or” in clause (vi) and in the second sentence of such section 1905(a).

TITLE IV—GENERAL

EFFECTIVE DATE

SEC. 401. The amendments and repeals made by the preceding provisions shall become effective, and section 9 of the Act of April 19, 1950 (25 U.S.C. 639) is repealed effective, on the first January 1 following the fiscal year in which this Act is enacted; except that—

(1) in the case of any State a statute of which prevents it from making the supplementary payments provided for in part E of

title IV of the Social Security Act, as amended by this Act, the amendments made by this Act and such repeal shall not apply with respect to individuals in such State until (if later than the date referred to above) the first July 1 which follows the close of the first regular session of the legislature of such State which begins after the enactment of this Act or until (if earlier than July 1) the first calendar quarter following the date on which the State certifies it is no longer so prevented from making such payments; and

(2) in the case of any State a statute of which prevents it from complying with the requirements of section 1602 of the Social Security Act, as amended by this Act, the amendments made by title II of this Act shall not apply until (if later than the January 1 referred to above) the first July 1 which follows the close of the first regular session of the legislature of such State which begins after the enactment of this Act or on the earlier date on which such State submits a plan meeting such requirements of section 1602;

and except that section 437 of the Social Security Act, as amended by this Act, shall be effective upon enactment of this Act.

MEANING OF SECRETARY AND FISCAL YEAR

SEC. 402. As used in this Act and in the amendments made by this Act, the term "Secretary" means, unless the context otherwise requires and except in part C of title IV of the Social Security Act, the Secretary of Health, Education, and Welfare; and the term "fiscal year" means a period beginning with any July 1 and ending with the close of the following June 30.

THE PRESIDENT'S MESSAGE ON WELFARE REFORM

THE WHITE HOUSE.

To the Congress of the United States:

A measure of the greatness of a powerful nation is the character of the life it creates for those who are powerless to make ends meet.

If we do not find the way to become a working nation that properly cares for the dependent, we shall become a welfare state that undermines the incentive of the working man.

The present welfare system has failed us—it has fostered family breakup, has provided very little help in many States and has even deepened dependency by all too often making it more attractive to go on welfare than to go to work.

I propose a new approach that will make it more attractive to go to work than to go on welfare, and will establish a nationwide minimum payment to dependent families with children.

I propose that the Federal Government pay a basic income to those American families who cannot care for themselves in whichever State they live.

I propose that dependent families receiving such income be given good reason to go to work *by making the first \$60 a month they earn completely their own, with no deductions from their benefits.*

I propose that we *make available an addition to the incomes of the "working poor,"* to encourage them to go on working and to eliminate the possibility of making more from welfare than from wages.

I propose that these payments be made upon certification of income, with demeaning and costly investigations replaced by simplified reviews and spot checks and with *no eligibility requirement that the household be without a father.* That present requirement in many States has the effect of breaking up families and contributes to delinquency and violence.

I propose that all employable persons who choose to accept these payments be required to register for work or job training and *be required to accept that work or training,* provided suitable jobs are available either locally or if transportation is provided. Adequate and convenient day care would be provided children wherever necessary to enable a parent to train or work. The only exception to this work requirement would be mothers of preschool children.

I propose a *major expansion of job training and day care facilities,* so that current welfare recipients able to work can be set on the road to self-reliance.

I propose that we also *provide uniform Federal payment minimums for the present three categories of welfare aid to adults—the aged, the blind, and the disabled.*

This would be total welfare reform—the transformation of a system frozen in failure and frustration into a system that would work and would encourage people to work.

Accordingly, we have stopped considering human welfare in isolation. The new plan is part of an overall approach which includes a comprehensive new Manpower Training Act, and a plan for a system of revenue sharing with the States to help provide all of them with necessary budget relief. Messages on manpower training and revenue sharing will follow this message tomorrow and the next day, and the three should be considered as parts of a whole approach to what is clearly a national problem.

Need for new departures

A welfare system is a success when it takes care of people who cannot take care of themselves and when it helps employable people climb toward independence.

A welfare system is a failure when it takes care of those who *can* take care of themselves, when it drastically varies payments in different areas, when it breaks up families, when it perpetuates a vicious cycle of dependency, when it strips human beings of their dignity.

America's welfare system is a failure that grows worse every day.

First, it fails the recipient: In many areas, benefits are so low that we have hardly begun to take care of the dependent. And there has been no light at the end of poverty's tunnel. After 4 years of inflation, the poor have generally become poorer.

Second, it fails the taxpayer: Since 1960, welfare costs have doubled and the number on the rolls has risen from 5.8 million to over 9 million, all in a time when unemployment was low. The taxpayer is entitled to expect government to devise a system that will help people lift themselves out of poverty.

Finally, it fails American society: By breaking up homes, the present welfare system has added to social unrest and robbed millions of children of the joy of childhood; by widely varying payments among regions, it has helped to draw millions into the slums of our cities.

The situation has become intolerable. Let us examine the alternatives available:

We could permit the welfare momentum to continue to gather speed by our inertia; by 1975 this would result in 4 million more Americans on welfare rolls at a cost of close to \$11 billion a year, with both recipients and taxpayers shortchanged.

We could tinker with the system as it is, adding to the patchwork of modifications and exceptions. That has been the approach of the past, and it has failed.

We could adopt a "guaranteed minimum income for everyone," which would appear to wipe out poverty overnight. It would also wipe out the basic economic motivation for work, and place an enormous strain on the industrious to pay for the leisure of the lazy.

Or, we could adopt a totally new approach to welfare, designed to assist those left far behind the national norm, and provide all with the motivation to work and a fair share of the opportunity to train.

This administration, after a careful analysis of all the alternatives, is committed to a new departure that will find a solution for the welfare problem. The time for denouncing the old is over; the time for devising the new is now.

Recognizing the practicalities

People usually follow their self-interest.

This stark fact is distressing to many social planners who like to look at problems from the top down. Let us abandon the ivory tower and consider the real world in all we do.

In most States, welfare is provided only when there is no father at home to provide support. If a man's children would be better off on welfare than with the low wage he is able to bring home, wouldn't he be tempted to leave home?

If a person spent a great deal of time and effort to get on the welfare rolls, wouldn't he think twice about risking his eligibility by taking a job that might not last long?

In each case, welfare policy was intended to limit the spread of dependency; in practice, however, the effect has been to increase dependency and remove the incentive to work.

We fully expect people to follow their self-interest in their business dealings; why should we be surprised when people follow their self-interest in their welfare dealings? That is why we propose a plan in which it is in the interest of every employable person to do his fair share of work.

The operation of the new approach

1. *We would assure an income foundation throughout every section of America for all parents who cannot adequately support themselves and their children.* For a family of four with income of \$720 or less, this payment would be \$1,600 a year; for a family of four with \$2,000 income, this payment would supplement that income by \$960 a year.

Under the present welfare system, each State provides "Aid to families with dependent children," a program we propose to replace. The Federal Government shares the cost, but each State establishes key eligibility rules and determines how much income support will be provided to poor families. The result has been an uneven and unequal system. The 1969 benefits average for a family of four is \$171 a month across the Nation, but individual State averages range from \$263 down to \$39 a month.

A new Federal minimum of \$1,600 a year cannot claim to provide comfort to a family of four, but the present low of \$468 a year cannot claim to provide even the basic necessities.

The new system would do away with the inequity of very low benefit levels in some States, and of State-by-State variations in eligibility tests, by establishing a federally financed income floor with a national definition of basic eligibility.

States will continue to carry an important responsibility. In 30 States the Federal basic payment will be less than the present levels of combined Federal and State payments. These States will be required to maintain the current level of benefits, but in no case will a State be required to spend more than 90 percent of its present welfare cost. The Federal Government will not only provide the "floor," but it will assume 10 percent of the benefits now being paid by the States as their part of welfare costs.

In 20 States, the new payment would exceed the present average benefit payments, in some cases by a wide margin. In 10 of these States, where benefits are lowest and poverty often the most severe, the payments will raise benefit levels substantially. For 5 years, every State

will be required to continue to spend at least half of what they are now spending on welfare, to supplement the Federal base.

For the *typical "welfare family"*—a mother with dependent children and no outside income—the new system would provide a basic national minimum payment. A mother with three small children would be assured an annual income of at least \$1,600.

For the family headed by an employed father or working mother, the same basic benefits would be received, but \$60 per month of earnings would be "disregarded" in order to make up the costs of working and provide a strong advantage in holding a job. The wage earner could also keep 50 percent of his benefits as his earnings rise above that \$60 per month. A family of four, in which the father earns \$2,000 in a year, would receive payments of \$960, for a total income of \$2,960.

For the *aged, the blind, and the disabled*, the present system varies benefit levels from \$40 per month for an aged person in one State to \$145 per month for the blind in another. The new system would establish a minimum payment of \$65 per month for all three of these adult categories, with the Federal Government contributing the first \$50 and sharing in payments above that amount. This will raise the share of the financial burden borne by the Federal Government for payments to these adults who cannot support themselves, and should pave the way for benefit increases in many States.

For the *single adult* who is not handicapped or aged, or for the *married couple without children*, the new system would not apply. Food stamps would continue to be available up to \$300 per year per person, according to the plan I outlined last May in my message to the Congress on the food and nutrition needs of the population in poverty. For dependent families there will be an orderly substitution of food stamps by the new direct monetary payments.

2. *The new approach would end the blatant unfairness of the welfare system.*

In over half the States, families headed by unemployed men do not qualify for public assistance. In no State does a family headed by a father working full time receive help in the current welfare system, no matter how little he earns. As we have seen, this approach to dependency has itself been a cause of dependency. It results in a policy that tends to force the father out of the house.

The new plan rejects a policy that undermines family life. It would end the substantial financial incentives to desertion. It would extend eligibility to *all* dependent families with children, without regard to whether the family is headed by a man or a woman. The effects of these changes upon human behavior would be an increased will to work, the survival of more marriages, the greater stability of families. We are determined to stop passing the cycle of dependency from generation to generation.

The most glaring inequity in the old welfare system is the exclusion of families who are working to pull themselves out of poverty. Families headed by a nonworker often receive more from welfare than families headed by a husband working full time at very low wages. This has been rightly resented by the working poor, for the rewards are just the opposite of what they should be.

3. *The new plan would create a much stronger incentive to work.*

For people now on the welfare rolls, the present system discourages

the move from welfare to work by cutting benefits too fast and too much as earnings begin. *The new system would encourage work by allowing the new worker to retain the first \$720 of his yearly earnings without any benefit reduction.*

For people already working, but at poverty wages, the present system often encourages nothing but resentment and an incentive to quit and go on relief where that would pay more than work. The new plan, on the contrary, would provide a supplement that will help a low-wage worker—struggling to make ends meet—achieve a higher standard of living.

For an employable person who just chooses not to work, neither the present system nor the one we propose would support him, though both would continue to support other dependent members in his family.

However, a welfare mother with preschool children should not face benefit reductions if she decides to stay home. It is not our intent that mothers of preschool children must accept work. Those who can work and desire to do so, however, should have the opportunity for jobs and job training and access to day-care centers for their children; this will enable them to support themselves after their children are grown.

A family with a member who gets a job would be permitted to retain all of the *first \$60 monthly income*, amounting to \$720 per year for a regular worker, *with no reduction of Federal payments*. The incentive to work in this provision is obvious. But there is another practical reason: Going to work costs money. Expenses such as clothes, transportation, personal care, social security taxes and loss of income from odd jobs amount to substantial costs for the average family. Since a family does not begin to *add* to its net income until it surpasses the cost of working, in fairness this amount should not be subtracted from the new payment.

After the first \$720 of income, the *rest* of the earnings will result in a systematic reduction in payments.

I believe the vast majority of poor people in the United States prefer to work rather than have the Government support their families. In 1968, 600,000 families left the welfare rolls out of an average caseload of 1,400,000 during the year, showing a considerable turnover, much of it voluntary.

However, there may be some who fail to seek or accept work, even with the strong incentives and training opportunities that will be provided. It would not be fair to those who willingly work, or to all taxpayers, to allow others to choose idleness when opportunity is available. Thus, they must accept training opportunities and jobs when offered, or give up their right to the new payments for themselves. No able-bodied person will have a "free ride" in a nation that provides opportunity for training and work.

4. *The bridge from welfare to work should be buttressed by training and child care programs.* For many, the incentives to work in this plan would be all that is necessary. However, there are other situations where these incentives need to be supported by measures that will overcome other barriers to employment.

I propose that *funds be provided for expanded training and job development programs* so that an additional 150,000 welfare recipients can become jobworthy during the first year.

Manpower training is a basic bridge to work for poor people, especially people with limited education, low skills and limited job experience. Manpower training programs can provide this bridge for many of our poor. In the new manpower training proposal to be sent to the Congress this week, the interrelationship with this new approach to welfare will be apparent.

I am also requesting authority, as a part of the new system, to provide child care for the 450,000 children of the 150,000 current welfare recipients to be trained.

The child care I propose is more than custodial. This Administration is committed to a new emphasis on child development in the first 5 years of life. The day care that would be part of this plan would be of a quality that will help in the development of the child and provide for its health and safety, and would break the poverty cycle for this new generation.

The expanded child care program would bring new opportunities along several lines: opportunities for the further involvement of private enterprise in providing high quality child care service; opportunities for volunteers; and opportunities for *training and employment in child care centers of many of the welfare mothers themselves.*

I am requesting a total of \$600 million additional to fund these expanded training programs and child care centers.

5. *The new system will lessen welfare redtape and provide administrative cost savings.* To cut out the costly investigations so bitterly resented as "welfare snooping," the Federal payment will be based upon a certification of income, with spot checks sufficient to prevent abuses. The program will be administered on an automated basis, using the information and technical experience of the Social Security Administration, but, of course, will be entirely separate from the administration of the social security trust fund.

The States would be given the option of having the Federal Government handle the payment of the State supplemental benefits on a reimbursable basis, so that they would be spared their present administrative burdens and so a single check could be sent to the recipient. These simplifications will save money and eliminate indignities; at the same time, welfare fraud will be detected and lawbreakers prosecuted.

6. *This new departure would require a substantial initial investment, but will yield future returns to the Nation.* This transformation of the welfare system will set in motion forces that will lessen dependency rather than perpetuate and enlarge it. A more productive population adds to real economic growth without inflation. The initial investment is needed now to stop the momentum of work to welfare, and to start a new momentum in the opposite direction.

The costs of welfare benefits for families with dependent children have been rising alarmingly the past several years, increasing from \$1 billion in 1960 to an estimated \$3.3 billion in 1969, of which \$1.8 billion is paid by the Federal Government, and \$1.5 billion is paid by the States. Based on current population and income data, the proposals I am making today will increase Federal costs during the first year by an estimated \$4 billion, which includes \$600 million for job training and child care centers.

The startup costs of lifting many people out of dependency will

ultimately cost the taxpayer far less than the chronic costs—in dollars and in national values—of creating a permanent underclass in America.

From welfare to work

Since this administration took office, members of the Urban Affairs Council, including officials of the Department of Health, Education, and Welfare, the Department of Labor, the Office of Economic Opportunity, the Bureau of the Budget, and other key advisers, have been working to develop a coherent, fresh approach to welfare, manpower, training, and revenue sharing.

I have outlined our conclusions about an important component of this approach in this message; the Secretary of HEW will transmit to the Congress the proposed legislation after the summer recess.

I urge the Congress to begin its study of these proposals promptly so that laws can be enacted and funds authorized to begin the new system as soon as possible. Sound budgetary policy must be maintained in order to put this plan into effect—especially the portion supplementing the wages of the working poor.

With the establishment of the new approach, the Office of Economic Opportunity will concentrate on the important task of finding new ways of opening economic opportunity for those who are able to work. Rather than focusing on income support activities, it must find means of providing opportunities for individuals to contribute to the full extent of their capabilities, and of developing and improving those capabilities.

This would be the effect of the transformation of welfare into “workfare,” a new work-rewarding system:

For the first time, all dependent families with children in America, regardless of where they live, would be assured of minimum standard payments based upon uniform and single eligibility standards.

For the first time, the more than 2 million families who make up the working poor would be helped toward self-sufficiency and away from future welfare dependency.

For the first time, training and work opportunity with effective incentives would be given millions of families who would otherwise be locked into a welfare system for generations.

For the first time, the Federal Government would make a strong contribution toward relieving the financial burden of welfare payments from State governments.

For the first time, every dependent family in America would be encouraged to stay together, free from economic pressure to split apart.

These are far-reaching effects. They cannot be purchased cheaply, or by piecemeal efforts. This total reform looks in a new direction; it requires new thinking, a new spirit and a fresh dedication to reverse the downhill course of welfare. In its first year, more than half the families participating in the program will have one member working or training.

We have it in our power to raise the standard of living and the realizable hopes of millions of our fellow citizens. By providing an equal chance at the starting line, we can reinforce the traditional American spirit of self-reliance and self-respect.

RICHARD NIXON.

THE WHITE HOUSE,
August 11, 1969

Proposed benefit schedule

APPENDIX

PROPOSED BENEFIT SCHEDULE (EXCLUDING ALL STATE BENEFITS) ¹

Earned income	New benefit	Total income
0.....	\$1,600	\$1,600
\$500.....	1,600	2,100
\$1,000.....	1,460	2,460
\$1,500.....	1,210	2,710
\$2,000.....	960	2,960
\$2,500.....	710	3,210
\$3,000.....	460	3,460
\$3,500.....	210	3,710
\$4,000.....	0	4,000

¹ For a 4-person family, with a basic payment standard of \$1,600 and an earned income disregard of \$720.

BACKGROUND MATERIAL

I. THE PRESENT SYSTEM

A. FAILURES

The present welfare system has been a failure; all indications are that its future will be worse, not better. In the last decade, the costs of aid to families with dependent children (AFDC) have more than tripled. The caseload has more than doubled.

Even more disturbing is the fact that the proportion of persons on AFDC is growing. In the past 15 years the proportion of children receiving assistance has doubled—from 30 children per 1,000 to about 60 per 1,000 at present.

B. INEQUITIES

Serious inequities exist under AFDC between regions of the country, between male- and female-headed families, and between poor people who work to help themselves on the one hand and the welfare poor on the other hand.

Average benefits for a female-headed family of four persons vary from \$39 to \$263 a month.

Only 24 States provide federally matched assistance to male-headed families, and this is only done where there is an “unemployed father” in the house—one who works no more than 30 hours a week. In no State is there now federally matched assistance for a male-headed family where the father works *full time*.

The present AFDC system encourages dependency. The preferential treatment of female-headed families has led to increased family break-up. In 1940, 30 percent of AFDC families had absent fathers; today it is over 70 percent.

II. THE NEW SYSTEM

A. COVERAGE

The administration's proposed welfare reform will provide direct Federal payments to *all* families with children with incomes below stipulated amounts.

The principal new group made eligible for cash assistance under the proposal is “working poor” families headed by males employed full time. The administration's proposed system would cover *both* “dependent families,” defined as those headed by a female or an unemployed father, and “working poor” families, defined as families headed by a full-time employed male.

B. BENEFIT LEVELS

1. Families with no earnings

The basic Federal benefit for a family of four would be \$1,600 per year, \$500 per person for the first two family members and \$300 for

each family member thereafter. A seven-person family with no earnings would receive \$2,500 per year.

2. *Families with earnings*

Families of four with earnings up to \$3,920 per year would be eligible for payments. Families of seven would be eligible up to \$5,720. All families would be allowed to "disregard" \$60 per month (\$720 per year) as work-related expenses—transportation, meals, clothing. Benefits would be reduced by 50 percent as earnings increase above \$720 per year.

C. AN EXAMPLE

A family of four with earnings of \$2,000 would be entitled to disregard the first \$720 in earnings.

Subtracting \$720 from \$2,000, the remainder is \$1,280. Fifty percent of this amount (\$640) is subtracted from the family's entitlement for benefits, which is \$1,600. The remainder (\$960) is added to the family's earnings of \$2,000. Its total income, therefore, would be \$2,960. (See chart II.)

A family of seven, with \$2,000 in income, using the same arithmetic, would be entitled to benefits of \$1,860 for a total income of \$3,860.

D. STATE SUPPLEMENTAL BENEFITS

In order that present benefit levels not be reduced for families aided under the existing AFDC program, the new system would require the continuation of State benefits equal to the difference between the proposed Federal minimum and a State's present benefit level. All States, however, would receive fiscal relief under the proposed welfare program.

States would not be required to supplement "working poor" families.

E. THE WORK REQUIREMENT

A basic element of the administration's welfare reform program is its emphasis on work, both a strong work requirement and the provision of incentives throughout the system for training and employment. (See chart VI.)

All applicants for benefits who are not working are required to register with the Employment Service.

Employable recipients must accept training or employment or lose their portion of the family's benefit.

F. TRAINING AND DAY CARE

To insure that employable recipients become self-sufficient, the administration's program provides a substantial increase in training opportunities and child care services. Training opportunities will be provided for an additional 150,000 welfare mothers. Child care services will be provided for an additional 450,000 children in families headed by welfare mothers.

G. ADMINISTRATION

Another important feature of the administration's welfare reform program is the national administration of the basic Federal benefit

for families. It is proposed that the administration of the system be assigned to the Social Security Administration in the Department of Health, Education and Welfare. The administration of the new system by the Social Security Administration would be handled entirely separate from its responsibility for the wage-related contributory OASDI programs.

III. COST OF THE PROGRAM

The estimated cost in the first full year of operation of the proposed welfare reform program is \$4 billion. This is additional to present Federal spending for public assistance, estimated at \$4.20 billion in fiscal year 1970.

Major cost components of the program are:

	<i>Billion</i>
1. Benefits to families-----	\$2.5
2. Adult minimum standards-----	.4
3. Training and day care to provide additional work opportunities for cash assistance receipts-----	.6
3. Other: Administration, effects on other programs, fiscal relief to States, and adjustments for lagged income reporting-----	.5
Total -----	4.0

A. BENEFITS TO FAMILIES

The estimate above of \$2.5 billion in additional spending for benefits to families is based on an inter-agency analysis of data from the OEO Survey of Economic Opportunity. The economic model for deriving this estimate uses data on 14,000 low income families and current research findings.

B. ADULT MINIMUM STANDARD

The administration's welfare reform program also establishes a Federal minimum payment level of \$65 per month for the three adult public assistance categories (aid for the blind, the disabled and the aged) and provides for the administrative combination of these programs.

Under this proposal, the Federal Government pays 100 percent of the first \$50; 50 percent of the next \$15; and 25 percent thereafter. Fiscal relief for State and local governments as a result of this Federal minimum for the adult categories is \$400 million.

C. TRAINING AND CHILD CARE

The total cost for training an additional 150,000 welfare mothers and providing child care services for an additional 450,000 children is \$623 million.

SUMMARY OF ADDED TRAINING AND CHILD CARE COSTS AND ENROLLMENTS

	Persons served (thousands)	Unit cost	Total cost (millions)
Training-----	150	\$1,110	\$165
Incentive payments-----	150	180	27
Child care-----	450	858	386
Upgrading-----	75	600	45
Total-----			623

IV. FISCAL RELIEF TO STATE AND LOCAL GOVERNMENTS

A. UNDER THE NEW WELFARE PLAN

Under the administration's proposed welfare reform program, all States receive fiscal relief. Each State is required to spend at least 50 percent of the amount spent in the base year for the present public assistance programs. No State, however, is required to spend more than 90 percent of expenditures in the base year for the four categories.

B. REVENUE SHARING

State and local governments are also aided under the administration's proposed revenue sharing program. The first full year effect of revenue sharing is \$1 billion. The amount of revenue sharing increases annually in five steps thereafter.

C. COMBINED IMPACT OF WELFARE REFORM PROPOSAL AND REVENUE SHARING

Combining the welfare reform and revenue sharing proposals, \$5 billion in new first-year funds is distributed as follows:

	<i>Billion</i>
Cash assistance benefits for the poor-----	\$2.2
Fiscal relief for State and local governments-----	1.7
Additional training and day care-----	.6
Other -----	.5
Total -----	5.0

The table attached provides State-by-State data on fiscal relief under both the administration's proposed welfare and revenue sharing reforms in their first full year of effect.

TABLE 1.—IMPACT ON STATE AND LOCAL GOVERNMENTS OF WELFARE REFORM AND REVENUE SHARING (FIRST FULL-YEAR EFFECT)

State	Revenue sharing	Fiscal relief under welfare reform	Total	State	Revenue sharing	Fiscal relief under welfare reform	Total
Alabama-----	16.1	11.9	28.0	Montana-----	3.9	1.4	5.3
Alaska-----	1.2	1.0	2.2	Nebraska-----	6.6	3.4	10.0
Arizona-----	10.1	3.4	13.5	Nevada-----	2.5	.9	3.4
Arkansas-----	9.5	6.2	15.7	New Hampshire-----	3.1	.9	4.0
California-----	112.5	179.5	292.0	New Jersey-----	31.1	25.2	56.3
Colorado-----	11.6	13.0	24.6	New Mexico-----	5.7	3.2	8.9
Connecticut-----	12.8	8.8	21.6	New York-----	117.1	43.9	161.0
Delaware-----	2.4	1.6	4.0	North Carolina-----	24.2	10.4	34.6
District of Columbia-----	3.4	4.1	7.5	North Dakota-----	3.5	.4	3.9
Florida-----	30.8	8.5	39.3	Ohio-----	41.2	32.0	73.2
Georgia-----	20.8	12.5	33.3	Oklahoma-----	12.6	19.3	31.9
Hawaii-----	4.8	3.3	8.1	Oregon-----	10.4	6.1	16.5
Idaho-----	4.0	1.0	5.0	Pennsylvania-----	53.3	43.2	96.5
Illinois-----	44.5	49.6	94.1	Rhode Island-----	4.3	5.2	9.5
Indiana-----	24.2	5.0	29.2	South Carolina-----	12.1	2.2	14.3
Iowa-----	14.6	7.0	21.6	South Dakota-----	3.9	1.2	5.1
Kansas-----	12.1	6.6	18.7	Tennessee-----	18.1	8.6	26.7
Kentucky-----	14.8	10.6	25.4	Texas-----	47.4	25.1	72.8
Louisiana-----	20.3	18.9	39.2	Utah-----	5.7	2.9	8.6
Maine-----	5.1	2.0	7.1	Vermont-----	2.4	1.2	3.6
Maryland-----	18.1	14.4	32.5	Virginia-----	20.4	4.7	25.1
Massachusetts-----	29.6	30.1	59.7	Washington-----	16.2	13.6	29.8
Michigan-----	40.8	35.5	76.3	West Virginia-----	9.0	4.5	13.5
Minnesota-----	21.5	9.3	37.8	Wisconsin-----	24.2	12.4	36.6
Mississippi-----	12.6	.9	13.5	Wyoming-----	2.1	.9	3.0
Missouri-----	20.4	18.3	38.7				
				Total-----	1,000.0	735.8	1,735.8

Written Statements Submitted by
Administration Witnesses Appearing
Before the Committee on Ways
and Means at Hearings on Social
Security and Welfare Proposals
Beginning on October 15, 1969,
Committee Print, Committee on
Ways and Means, U. S. House of
Representatives.

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

WRITTEN STATEMENTS SUBMITTED BY
ADMINISTRATION WITNESSES
APPEARING BEFORE THE
COMMITTEE ON WAYS AND MEANS
AT HEARINGS ON
SOCIAL SECURITY AND WELFARE
PROPOSALS
BEGINNING ON OCTOBER 15, 1969



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(III)

Statement
by
Robert H. Finch
Secretary of Health, Education, and Welfare
before the
Committee on Ways and Means
U. S. House of Representatives
Wednesday, October 15, 1969, 10 AM

Mr. Chairman and Members of the Committee:

I am pleased to testify before your Committee today. I know of the outstanding performance of this Committee during the past 34 years in connection with social security legislation. And I have had the opportunity to observe the excellent working relationship that exists between the Committee and the Department of Health, Education, and Welfare.

Over the past several months, many of us in the Department of Health, Education, and Welfare have devoted much of our time and efforts to the subject areas covered by the Social Security Act.

My presentation is not a definitive statement on the Social Security Act, but rather is an attempt to deliver an overall view of the Administration's position on necessary reforms.

President Nixon has sent several Messages to the Congress this year recommending amendments to the Social Security Act. The emphasis of these proposals is three-pronged; first and principally on jobs, second on an assured income growing out of social security and unemployment insurance when the worker's income is cut off, and finally on a supporting work-oriented family assistance program. These amendments propose: -- a sweeping and much-needed reform of assistance programs that aid families

with children -- changes in the assistance programs for the needy adults who are old, blind, or disabled -- increased social security cash benefits -- a system for automatically guaranteeing that the purchasing power of social security benefits will be kept up to date with future increases in prices -- broadened protection by social insurance programs -- a restoration of the actuarial balance of the hospital insurance trust fund.

The new Family Assistance Plan recognizes that everyone who can do so should have the opportunity to work and support himself and his family. The program provides for greatly expanded training opportunities, expanded facilities for children of working mothers, and greatly increased work incentives within the design of the assistance program itself.

Registration for work and training is a key part of the new approach, but even more important is the emphasis upon expanded opportunities for the individual. We do not want to continue a situation in which large numbers of people have little choice but to rely solely upon assistance payments for the support of their families. We want rather to develop a system which gives people the opportunity and incentive to become independent and self-supporting.

We believe too, that to the extent possible we should prevent need through social insurance rather than rely upon an assistance program to meet need after it has arisen. The worker should have the opportunity, as he works, to earn protection against the possible loss of his earnings. This is the function of social security and unemployment insurance -- to

give the worker and his family basic security against the loss of earned income arising because of unemployment, disability, old age, or death. Thus, the Administration's proposals in the areas of unemployment insurance and social security are complementary to our recommendations in the welfare area.

Medicare, Medicaid and maternal and child health programs are designed to help meet the medical needs and expenses of older people and those with low incomes and therefore are supplements to our income support program. We are proposing a number of changes in these programs which we feel will be the beginning of the control of rising costs in these programs.

Mr. Chairman, each of these proposals should be understood in context as well as individually. Therefore, I will give an overview of each of the proposals, after which other officials of the Department will present a more indepth analysis of each proposal.

I will first examine the urgently needed Family Assistance Program, then comment on social services, proceed to the social security amendments, and then finish my formal statement with a discussion of rising health costs and the immediate steps we are taking within the Department.

The Family Assistance Act of 1969

Mr. Chairman, I welcome this opportunity to discuss H.R. 14173, the Family Assistance Act of 1969.

This measure is the product of months of intensive study, beginning even before the inauguration with the President's Transition Task Force. After analyzing many proposals offered by recognized experts within and without the Federal Government, we have concluded that a radical reform of the structure of welfare is needed.

We sought, in designing the Family Assistance Plan, to identify and deal directly with the most pressing problems facing public welfare today. While it is a far-reaching and fundamental reform of public welfare, the Family Assistance Plan is a practical and pragmatic program. It is neither a universal income maintenance system, which we cannot afford at the present time, nor a guaranteed annual income, which we feel could undermine an individual's motivation and rewards for work.

This problem solving approach, rather than a theoretical approach, highlighted the following key areas which needed immediate solution and redirection:

1. The gross inequities that existed between categories of persons equally in need under the present welfare system;
2. The gross inequities from State to State;
3. The increasingly complex and controversial management crisis in welfare; and
4. The economic incentives which, in the present system, weigh more in favor of continued dependency and family break-up than the reverse.

The program we support is directed toward helping needy people to help themselves through work incentives and work requirements bolstered by expanded training and day-care opportunities, toward an elimination of the family break-up incentive, and toward the establishment of National minimum payment and eligibility standards. It would do these things in a way that will not further add to State fiscal burdens.

Public Assistance Today

In June 1969, a total of 10.2 million persons received public assistance from Federal, State and local funds. Of these, somewhat less than 800,000 were recipients of general assistance in which the Federal Government played no part. Among the 9.4 million persons receiving aid under Federally aided programs, slightly less than 1/3 were the adult categories--the aged, blind, the disabled--and nearly 6.6 million persons--over 2/3--were recipients under the program of Aid to Families with Dependent Children.

The Adult Categories

In the adult categories the situation is a relatively stable one, with the caseload increasing by about only 3.5 percent in the last year. Slightly over 2 million needy aged persons received assistance in June, an increase of only 17,000 over the preceding year. Their payments averaged \$70.55 a month. However, nearly 60 percent of these persons also received social security benefits so that their total incomes were significantly higher than assistance payments alone. Old-Age Assistance

(OAA) recipients constituted 10.4 percent of the persons in the country over age 65. However, this proportion varied widely. It was 2.7 percent in Connecticut and 40.7 percent in Louisiana.

The caseload of blind recipients has been consistently about 80,000 persons during the past year. The permanently and totally disabled numbered 755,000 in June, an increase of 85,000 over a year ago. Among the blind and disabled, about 20 percent also have social security benefits.

In view of the relatively stable caseloads in the adult programs, we felt that the major problems which they present are very low benefits in some States (less than \$39.40 a month under OAA in Mississippi in June 1969, ranging up to \$116.25 in New Hampshire) and differences in eligibility requirements among the various States.

We propose to continue as a Federal-State program a combined program for needy, aged, blind, and disabled persons. We propose, however, to establish for the first time a Federal floor--\$90 a month--of income and assistance which would be assured to adult recipients in any State. This new Federal floor would act to raise benefits for about 1/3 of the present OAA recipients, or about 670,000 persons, and would push up benefit levels in the 13 lowest payment States, plus the District of Columbia. The \$90 floor, when aggregated on a yearly basis for an aged couple, comes to \$2160, an amount which is actually slightly above the poverty line of \$2100 for an aged couple as that line has recently been redefined for 1968.

We make this proposal for a Federally established income floor for the adult categories in recognition of the fact that neither work incentives nor family stability incentives are the answer to the dependency of these people. We must do what we can through social and rehabilitation services to bolster self-support and self-care capacity among these recipients, but in the last analysis it must be our obligation to move toward an adequate level of income support for the aged, blind and disabled. Adequate income support where it is necessary is one of the measurements of a just and humane civilization.

We further propose to make uniform the definitions of resources, used in determining family eligibility under the program. Certain options for administration of these payments are also opened up to harmonize this system with the Family Assistance Plan, and those options will be discussed later.

In order to make these reforms possible we are proposing a liberalized formula for Federal financial participation under which the Federal Government would provide an average of \$50 per month to recipients, half of the next \$15, and 1/4 of additional amounts. The formula for Federal participation would, of course, apply only to payments actually made. This would provide substantial fiscal relief to most States.

THE AFDC PROGRAM

Most of the controversy around welfare programs centers around the program called AFDC--Aid to Families with Dependent Children. In this program costs have more than tripled since 1960 to an estimated total of more than 4 billion dollars in this fiscal year. The Federal Government will pay about half of this cost. During the same period, the number of recipients has more than doubled to a present total of more than 6.5 millions.

The rate of growth has been alarming and verging recently on the catastrophic. It took 15 years for AFDC payments to reach the half billion dollar mark, and another ten years to break a billion. But what took from 1935 to 1960 was duplicated in the short period from 1960 to 1967 when another billion dollars was added to payments. And in the next year alone payments soared by a half billion dollars.

Even more disturbing is the fact that the proportion of persons on AFDC is growing. In 1955, 30 children out of each thousand received aid. In June more than 60 children out of each thousand received aid. In studying the program, our estimates indicated that by the fiscal year 1975, costs would again double and numbers of persons increase by another 50-60 percent.

In spite of its growth and its cost, the program is beset by inequities. Children of a parent who has died, is incapacitated, or is absent from the home, are eligible in all States. Those with an unemployed father are eligible in about half the States. Those with a father

employed full-time are not eligible in any State. Thus a premium is placed on a home breaking up and an incentive exists for the breadwinner to leave.

Many fathers work full time but still do not earn as much as is available to families on welfare who may live nearby. The discontent of the working poor is understandable and destructive to the fabric of our society. The exclusion of the working poor is also the central structural defect of the system since it is what creates the family breakup incentive and undermines the rewards of work. This exclusion also has begun to take on ominous and socially polarizing racial overtones, for AFDC recipients--those who are helped--are about 50 percent nonwhite while the working poor--those who are excluded--are 70 percent white.

The State-to-State inequities which I described with respect to the adult programs are magnified in the AFDC program. In June, a recipient in Mississippi averaged \$10.20 per month. In New Jersey, recipients got an average of \$66.40. In Indiana, 22 children out of each thousand received aid. In New York, 107 children out of each thousand were helped.

In sum, in spite of the size of the effort, AFDC has engendered bitterness and resentment.

The poor who receive it have organized to fight those who administer it.

Many poor who are eligible continue to deprive themselves rather than submit to its indignities.

The middle class, far removed from the need for welfare and the people who receive it, is angry both at the cost in taxes and at the behavior attributed to some welfare recipients.

The large cities resent the flow of poor people from rural areas where welfare benefits are often inhumanely low.

State governments, staggered by the fiscal impact, cry out for relief.

Against this background, we concluded that major structural reform was necessary to correct, insofar as possible, the inequities of the old system. The first priority of the Family Assistance Plan has been to remove, or at least minimize the disincentives and inequities of present welfare policies. It is designed to strengthen family life and to provide strong and effective incentives for employment. This strategy may not pay off immediately, but unless this investment is made now, fundamental reform will be even more expensive in the future.

The Family Assistance Plan also provides some fiscal relief for hard-pressed States and at the same time raises benefit levels for recipients in those areas where they are lowest. But these goals, it must be said, cannot be our first priority at the present time. There are others who would invest more of our available resources in benefit increases or in a federalization of the program designed to provide maximum fiscal relief to the States. These are not easy priorities to weigh and balance, but we have concluded that--while those other approaches might be politically more popular in many respects--they only pour more Federal money into a system doomed to failure. The system must be

changed, not just its payment levels or the division of labor between the Federal and State governments within it.

The Family Assistance Plan

1. Help for the Working Poor

We propose to replace the present AFDC program with a new program, "The Family Assistance Plan," which would provide direct Federal payments to all needy families with children. Unlike the present program of Aid to Families with Dependent Children, the new plan would for the first time provide Federal benefit payments for families headed by full-time male workers as well as for families headed by a mother or an unemployed father. No State today provides assistance under AFDC for a family headed by a father who is working full time—even though the family may be living in poverty. This is the group of some 2 to 3 million families which we call "the working poor." A few States have already undertaken this structural reform on their own initiative by providing help through their general assistance programs to some or all of the working poor.

The Federal benefits would also be provided throughout the Nation to families headed by unemployed fathers. Today such assistance is available in only 25 of 54 jurisdictions. Eligibility of the working poor for assistance and a nationwide program for families headed by an unemployed father are the critical steps toward eliminating the harshest inequities of the present system. Without including the working poor, fundamental improvement of the work and family stability incentives is impossible.

2. The Family Unit

As indicated by the term "family assistance," the new program is based upon the existence of a family unit. The presence of a child in the household is, therefore, the key to eligibility in this proposal. When a family meets income and resources tests, payments under the plan would be made for all members who are related by blood, marriage, or adoption, as long as there is at least one family member who is under age 18, or under 21 if regularly attending school.

3. Treatment of Resources

Under the present public assistance programs, families with substantial resources are not eligible for payments because they could become at least temporarily self-supporting by converting all or part of their resources into cash or income-producing property. This concept and rationale is retained in H.R. 14173. Families with more than \$1500 in resources other than their homes, household goods, personal effects, and other property essential to their means of self-support, are not eligible for assistance payments under this proposal.

4. Basic Amount of Payment

The basic yearly Federal payment for an eligible family would be at the rate of \$500 a person for the first 2 family members and \$300 for each additional member, less whatever nonexcluded income the family has. This would establish a Federal income floor of \$1600 per year for a family of four with no other income.

5. Treatment of Income

Generally, assistance benefits would be reduced \$1 for each \$2 of earned or unearned income that the family has. This kind of offset would provide an incentive for the family to work and increase its earnings. The treatment of unearned income on the same basis as earned income eliminates an important inequity in the present law. Under AFDC, since unearned income is offset dollar for dollar against benefits, while benefits are reduced by 67 cents for a dollar of earned income (after the first \$30 per month of earnings which are completely excluded), families with the same incomes are treated very differently in terms of eligibility and amount of benefits depending on the source of their income.

6. Incentives to Work

As an additional work incentive, and to cover the costs of going to work, the first \$180 of earnings in a calendar quarter (\$720 a year) would be completely excluded or disregarded in determining the amount of payments for a family. An example might be useful at this point--suppose a family of four had earnings of \$2000 a year. The family would first be allowed to disregard \$720. Then 50 percent of the remaining \$1280 of earnings would be disregarded. The family's payment of \$1600 would then be reduced by the nondisregarded earnings of \$640 (50 percent of \$1280), giving the family assistance payment of \$960 and--combined with the earnings of \$2000--a total income of \$2960.

There would not be a reduction in the amount of payments for the value of food stamps and other public assistance or private charity.

7. Families Helped to Become Self-Sufficient

The new system is designed to fulfill the mandate of the President that government has "no less of an obligation to the working poor than to the nonworking poor; and for the first time, benefits would be scaled in such a way that it would always pay to work."

But the built-in guarantee that people would always be better off by working would be bolstered by strong work requirements in the system itself. Members of families that apply for assistance payments under the plan would be required to register for employment or training with the local public employment office and to accept a training or suitable job opportunity when offered. Failure to register or accept such a job or training opportunity would result in termination of the individual's benefits. All able-bodied adult family members would be subject to these provisions, with certain defined exceptions of which the major ones involve exemptions for mothers with children under six years of age and for other mothers where the father is present in the home as the primary worker.

The rationale for these provisions is well known to this Committee, which initiated similar requirements as part of the 1967 amendments to the Social Security Act. It was well stated in the President's Message to the Congress on August 11:

"...there may be some who fail to seek or accept work, even with the strong incentives and training opportunities that will be provided. It would not be fair to those who willingly work, or to all taxpayers, to allow others to choose idleness when opportunity is available. Thus, they must accept training opportunities and jobs when offered, or give up their right to the new payments for themselves. No able-bodied person will have a "free ride" in a nation that provides opportunities for training and work."

To make these work incentives and requirements effective, we are seeking a major expansion of our job training, employment and child care programs. Family members referred for training and accepted in a program will receive a monthly training allowance of \$30 in addition to their family assistance benefits and supplementary State payments, or the normal manpower training allowance in lieu of these if it is higher. Over \$600 million is being requested for these elements, of which \$386 million is for the child care component, and we will be joining with the Department of Labor in a new interdepartmental mechanism to make these programs do the job.

8. Child Care

The provisions for child care and supportive services under H.R. 14173 are an essential supporting element in our efforts to make it possible for welfare recipients to obtain training and employment. It is an established fact that inadequate care of the children of a trainee or employee can result in the early withdrawal of that person from the labor market, and the absence of child care can often mean no initial participation. Past experiences in programs sponsored by the Labor Department and the Office of Economic Opportunity have

demonstrated the difficulties of lack of day care. Particularly tragic have been the cases in which women have enthusiastically entered into training programs with day care provided, only to discover that the day care disappears when they are ready to go to work.

Beyond the value of the day care to the working parent there are enormous benefits which accrue to the child who is enrolled in a comprehensive child development program. We now know that the child of poverty needs far more than custodial care if developmental deficits are to be overcome. It is this type of comprehensive child care involving educational, medical, dental, nutritional and follow-up activities, that is contemplated by the President's recommendations.

There could also be substantial benefits to those at the opposite end of the age spectrum, the Nation's elderly. Among our Nation's older population there is a tremendous reservoir of men and women talented in working with children. It has been the experience of the Department of Health, Education, and Welfare, in administering the Foster Grandparents Program and other programs employing the elderly to serve children that increased opportunities for interaction between the elderly and children can not only provide a needed income supplementation for the elderly, but can also have beneficial effects for both age groups.

A family receiving benefits will be eligible for the child care services whenever such care is necessary to permit an adult member to undertake, or continue in training or employment. This care may be provided in the child's own home, in a family day care home or in group day care.

New ground is being broken by the proposal to provide grants directly to State or local public agencies or nonprofit private agencies or organizations, and to contract with public or private agencies or organizations to provide such child care. The need for day care is so great that we believe it will be necessary to use a wide variety of competent organizations.

I believe that this provision opens the door to a wider utilization of resources than we have been able to obtain in the past. It enables the Federal Government to take the direct initiatives to get the program moving and to assure the effectiveness of the training and employment components. The same provision would also enable the Federal Government to contract with businesses, industry, and with labor unions to provide day care services for the children of their employees and members who have been involved in the Family Assistance Program. We have long been seeking ways to expand the participation of these groups in the provision of day care services, because of the obvious benefits to the employer, the employee, and the child.

H.R. 14173 would fund up to 90 percent of the cost of child care projects, and would permit the 10-percent non-Federal share to be provided in the form of services or facilities when approved by the Secretary. Our experience has been that States and local communities have all-too-often been unable to undertake day care projects because of their inability to provide the 25-percent non-Federal, or local share under present law.

In the past, programs have been jeopardized or shelved because the projects in local communities could not afford to finance the alterations, remodeling, or renovation of facilities necessary to meet local licensing standards. H.R. 14173 authorizes funds to be used for these purposes.

The proposal also authorizes the Secretary to require families to pay for all or part of the cost of child care services when there is an ability to do so. However, the Secretary may prescribe regulations which permit the family to deduct all or part of such costs from the earned income which otherwise would reduce the assistance payment.

The President has made a National commitment to the needs of children in the vital first five years of life. H.R. 14173 would help the Nation take considerable strides toward fulfilling this commitment. Calling for an expenditure of \$386 million for the first year of operation, 300,000 school-aged children will be able to receive services after school and during the summer months, at an estimated cost of \$4.00 per child. In addition, 150,000 preschool children could receive full-day services, at a cost of \$16.00 a child. The balance would be applied to research and demonstration projects, to the training of personnel and to alteration or renovations of facilities.

I should like to stress that in all phases of the implementation of this legislation it is our firm and committed intention to work closely with the appropriate State agencies to coordinate all day care efforts under State and local auspices.

State Supplemental Payments

We recognize that the new Federal income floor of \$1600 per year for a family of four (\$133.33 per month) is not adequate to support needy families without other sources of income. Nevertheless, it represents a substantial improvement in the level of payments now made in eight States, and could be made more adequate when budget conditions permit. To assure the maintenance of present payment levels for families receiving public assistance, States that now provide a level of assistance higher than the proposed Federal floor are required to continue to pay the difference between the Federal floor and what they are now paying. In eight States, the new family assistance payments would exceed the present Federal-State payments under AFDC—in some cases by a wide margin.

The AFDC payment for a family of four is \$133 per month or less in the following States as of July 1969:

Alabama	\$ 81.00
Arkansas	100.00
Georgia	133.00
Louisiana	119.00
Mississippi	70.00
Missouri	130.00
South Carolina	99.00
Tennessee	129.00

Accordingly, on the average, 42 States will be required to supplement families above the Federal minimum floor. This supplementation is a requirement that States must meet to continue to receive Federal funds to help finance other Federal-State welfare programs, including the adult category programs, maternal and child health and crippled childrens programs, social services, and medicaid. These States will be required to supplement in the case of families eligible under AFDC and AFDC-UF (unemployed father) programs, but they will not be required to supplement the new "working poor" recipients.

Costs of the Program

The estimated new Federal cost for all the proposals included in the Family Assistance Act is \$4.4 billion per year. This estimate is based on data for calendar year 1968 and assumes 100 percent program participation by eligible families and persons. The \$4.4 billion is the incremental or new cost of the program, and is in addition to the \$3.2 billion in Federal funds spent on welfare in 1968.

This figure of \$4.4 billion is higher than the \$4.0 billion estimate in the President's Message of August 11, largely as a result of the recent decision to treat unearned income like earned income in the "disregard" provision.

The following table shows the cost estimates for each of the Act's major provisions:

<u>Provision</u>	<u>Added Federal Cost (billions)</u>
Family Assistance payments	\$3.0
Adult Public Assistance changes	0.4
Federal Payment to States (Part E)	0.1
Training and Day Care	0.6
Administration and Other	<u>0.3</u>
Total	\$4.4

Being particularly conscious of the difficulty of producing reliable cost estimates in this field, and mindful of the variations of the actual experience from the projections which have been provided to the Congress

in previous years, we have taken extreme care in arriving at these figures. The methodology used was worked out under the leadership of the Bureau of the Budget in an interagency procedure involving this Department, the Department of Labor, the Office of Economic Opportunity, the Council of Economic Advisers, and the President's Commission on Income Maintenance. The most recent survey data on personal income available to the Federal Government was used.

Nevertheless, we have thought it prudent to request that an entirely independent estimate of the critical item, the family assistance payments costs, be made by the Chief Actuary of the Social Security Administration. That estimate shows a net cost of \$3.5 billion for family assistance payments for calendar year 1971, a figure reasonably close to the calendar 1968 figure of \$3.0 billion produced by the inter-agency group. We hope to have that latter figure brought up to date in 1971 terms very shortly and will supply it to the Committee.

In light of this double-checking procedure, and given the difficulty of estimating costs on a new program of this magnitude, we feel reasonably confident in suggesting that the payment costs of the Family Assistance Plan will fall in the range of \$3.0 to \$3.5 billion in 1971.

Fiscal Relief to State and Local Governments

Under the Administration's proposed welfare reform system, all States would receive some fiscal relief. For each of the first five years after enactment, each State would be required to spend at least

50 percent of the amount that it would have spent under the present public assistance programs if they were continued. No State, however, would be required to spend more than 90 percent of the expenditures it would have incurred in any of these 5 years under existing law. Thus, fiscal relief to an individual State under this "50-90" rule will vary between 10 percent and 50 percent of what they would spend under existing law.

Administration of the Family Assistance Plan

The major job of administering the Family Assistance Plan will be performed by the Social Security Administration of the Department of Health, Education, and Welfare.

The Social Security Administration has developed over the past 34 years an expertise in the delivery of cash payments on a regular basis to millions of Americans. This experience and expertise will be brought to bear on many of the administrative problems in the Family Assistance Plan.

In determining initial and continuing eligibility, initial reliance would be placed upon detailed statements provided by applicants. Recipients of family assistance payments will be required to periodically report changes in income, family composition, and other factors related to eligibility and amount of benefits. The Social Security Administration will use the regular reports of earnings it receives in the course of

administering the social security program to verify past and present earnings and estimates made in the applicant's declaration of income. In-depth verification will normally be done on a sample basis, but will be used on a wider scale if experience indicates a need to do so.

Major Effects of the Welfare Reforms

By combining powerful work incentives and requirements, by including the working poor, by allowing a family to disregard \$60 per month for work expenses, and by requiring that able-bodied adults register for training or employment, the Family Assistance Plan would help families to help themselves. The plan is therefore not an income guarantee, but rather a program of support for those who demonstrate a willingness to help support themselves.

By treating male-headed and female-headed families equally, the Family Assistance Plan would remove a major incentive for a father to leave home so that his family could qualify for welfare. In fact, the Family Assistance Plan provides an incentive for the father to remain at home because his presence increases the amount of the family's total benefit. Also, the provisions creating eligibility for assistance to families headed by a working male should reduce the incentive for employed men to separate from their families.

By establishing a national minimum payment and national eligibility standards the plan would reduce the inequities of the present program. In every State, the Federal payment for a family of four with no income

would be \$1600, and when benefits under the President's food stamp proposal are taken into account, the value of the assistance to such a family would be about \$2350 per year. In eight States, accounting for about 20 percent of present recipients, family payment levels will be increased. The new income floor will provide the aged couples with an income slightly above the current poverty line.

The Family Assistance Plan, combined with the Manpower Training Act, would provide a simplified and decentralized framework within which expanded training and day care facilities would greatly broaden the opportunities for assistance recipients to become self-sufficient economically productive contributors to our economy. Over 150,000 new training opportunities along with 450,000 quality child-care positions would be funded under this plan.

By providing for a new and separate revenue-sharing program along with the "50-90" rule, the plan would assure the States desperately needed fiscal relief. Furthermore, creation of a Federal program to cover the working poor and prevent their slipping into dependency, the States would be relieved of what might well have been the burden of increases in the welfare costs.

In summary, the Family Assistance Plan will, for the first time, insure minimum standards of payments for families with children, wherever they live. It will establish a new minimum standard of \$90 for the aged, blind, and disabled. It will help able-bodied people become self-sufficient. It will provide training and work placement opportunities.

It will provide needed fiscal relief for the States. It will remove the economic incentive in the present welfare system for families to split apart.

We believe this comprehensive plan provides the best vehicle for this Nation to help break the poverty cycle. As the President said in his August 11th message, "We have it in our power to raise the standard of living and realizable hopes of millions of our fellow citizens. By providing an equal chance at the starting line, we can reinforce the traditional American spirit of self-reliance and self-respect."

Social Services

Mr. Chairman the major emphasis in this discussion has been, properly I think, on income maintenance. We are mindful, however, of the need for social and rehabilitation services as an essential corollary to an effective income maintenance program. The complexity of the problem faced by assistance recipients and other low income persons often seriously affects their ability to work, to care for themselves, and to provide necessary care for their children.

The Family Assistance Plan amendments provide, basically, for continuing the present arrangements for services. Our experience since the 1962 and 1967 legislation, however, indicates a need for improvements. In the development and planning work now being done, we are reconsidering the principles upon which we should base our service program, and we are analyzing the community resources which could be brought into the picture. We are convinced that, at least for

services, coverage should not be limited to those who receive public assistance. There are many persons who are not public welfare recipients for whom social and rehabilitation services can be as helpful as they are for public assistance recipients. Services at an appropriate time may avert the need for assistance.

We are also very much concerned about this situation with respect to foster care and adoption services. We believe that we must find ways to provide suitable help and leadership in these basic child welfare functions.

Another matter to which we are directing our efforts is the coordinating of the services program more closely with the resources of the State and local vocational rehabilitation agencies. Those agencies have a fine record of achievement in the rehabilitation area. We want to make full use of their resources. The Family Assistance Plan recognizes this and provides for the referral of persons who are not sent to employment offices because of incapacity or disability to a vocational rehabilitation agency.

We are aware of the interest of this Committee in this matter as indicated by the 1962 and 1967 amendments. I want to assure you of the deep concern of this Administration in these fields. These problems are high on our agenda. We are now working on ways to develop a more effective service program. We will be sending you definite legislative recommendations in the near future.

Social Security

Mr. Chairman, let me turn next to the social security proposals. I will discuss the highlights of the President's recommendations for social security and then later Commissioner Robert M. Ball will give a more detailed presentation.

The Administration bill is H.R. 14080, introduced by the Minority Leader, Mr. Gerald Ford of Michigan, and companion bills H.R. 14162 and H.R. 14134, introduced by Representatives Collier and Chamberlain respectively. Mr. Byrnes and Mr. Bush have introduced identical bills except that their bills would have an effective date for the 10-percent increase in cash benefits payments of January 1970 instead of March 1970.

Social Security Benefit Increase

The President has recommended a benefit increase to bring the benefits up to date with increases in the cost of living that have occurred since the last benefit increase in February 1968.

The increase would apply to all beneficiaries, including those getting the special payments for certain people age 72 and older. Under the proposal, effective for March 1970, benefits would be increased for all the 25 million beneficiaries. The total additional benefit outlays for the first full calendar year in which the increase is effective would be approximately \$3 billion.

Automatic Cost of Living Increase

Beyond the initial 10 percent increase, the President has recommended that provision be made in the law for social security benefits to be automatically adjusted for future increases in the cost of living. The platforms of both political parties recognized the need to have a way of keeping the social security program automatically up to date. Such an automatic adjustment system would increase the security of the one out of every 8 people in the country who now receive monthly social security cash benefits. The automatic provision would also adjust the benefits for the millions of future beneficiaries whose major source of income could well be their social insurance payments under social security. Because of the time lags that have occurred between past cost of living adjustments of benefits, the purchasing power of the benefits has been seriously decreased between benefit increases. With automatic adjustments, the changes necessary to restore purchasing power will be on a more current basis.

The Administration proposal finances the automatic increases in benefits without increasing social security contribution rates. This can be done so long as the contribution and benefit base, the maximum amount of annual earnings counted for social security purposes, is increased from time to time. The legislation we support contains a provision to automatically adjust this base in the future to keep pace with increases in earnings levels.

Retirement Test

H.R. 14080 also includes important changes in the social security retirement test--the provision under which benefits are not paid in full if a beneficiary has substantial earnings. This provision has been the object of widespread criticism.

The measure provides for replacing the present dollar-for-dollar reduction in benefits which now applies for earnings above \$2880 in a year with a provision under which there would be a \$1 reduction for each \$2 earned. With this change people would have an incentive to earn more because the more they earn the more spendable income they would have.

The President also recommends updating the retirement test to take account of increases in earnings levels. It is proposed that the amount a person can earn in a year without having any benefits withheld be raised from \$1680 to \$1800, and then automatically adjusted upwards in future years as earnings levels rise.

The recommended changes in the retirement test would benefit approximately 1.1 million people. Additional benefits of \$330 million would be paid for months in calendar 1971.

Contribution and Benefit Base

The President is recommending that the social security contribution and benefit base be increased in 1972 from the \$7800 now in effect to \$9000. This change will very closely maintain the relationship between the base and the general level of earnings that has prevailed since the

early 1950's. As indicated earlier he also recommends that after 1972 the base be kept up to date with rising earnings levels in the future.

Increases in Widows Benefits

Under present law, a widow who begins receiving benefits at age 65 is entitled to 82 1/2 percent of the amount of the spouse's primary benefit. Under this proposal, such a widow would be entitled to 100 percent of the spouse's primary benefit. The 82 1/2 percent rate will continue to apply to widows going on the rolls at age 62, with graduated proportions for ages above 62 and below 65.

An estimated 2.7 million people would have their benefits increased under this provision. On the average, the increase would amount to \$17 per month (in addition to what widows would get under the 10-percent general benefit increase). Additional benefit payments in the first 12 months under the provision are estimated at \$580 million.

Uniform Method of Computing Benefits for Men and Women

Under present law, the number of years over which a man's average monthly earnings (on which his benefits are based) and his eligibility for benefits are determined are figured up to age 65. For women these determinations are made up to age 62.

The President has recommended that the method of computing benefits for men and women be made uniform--as of age 62. As a result, the treatment of men and women workers under the benefit provisions would be the same; and the retirement benefits payable to men, the benefits payable

to their wives, and the benefits payable to survivors of men who live beyond age 62 would be increased.

About 5 million people--workers, dependents, and survivors--would have their benefits increased because of the change in computing the average monthly wage. In addition, about 100,000 people--75,000 men age 62 and over 25,000 dependents--would become newly eligible for benefits because of the liberalized insured-status requirement for men age 62 and over. Additional benefit payments in the first 12 months are estimated at \$380 million.

Other Social Security Proposals

We are also proposing a number of important but less far-reaching improvements in the social security program. The bill would provide benefits for people disabled since childhood where the disability began before age 22, rather than age 18 as under present law. The bill would also provide for the payment of benefits to the aged dependent parents of retired or disabled workers. Under present law, parent's benefits are payable only to the dependent parents of insured workers who have died. And, finally, the bill would extend the \$100 a month noncontributory wage credit for military service that was provided in the 1967 social security amendments for members of the armed services after 1967. Under the bill these credits would be available for the period from 1957, when regular social security coverage of members of the armed services began, through 1967. About 190,000 people would be immediately affected by these three proposals, and additional benefit payments in the first 12 months would be about \$60 million.

Financing

The President's recommendations include financing provisions that would cover the cost of the proposed improvements in the social security program and correct the present actuarial deficit in the hospital insurance program. Moreover, a revised schedule of contribution rates in the cash benefits program would reduce the very large accumulations of income over outgo that would result from the schedule in present law.

The hospital insurance trust fund requires additional income over and above that scheduled under present law in near-future years. Without the proposed increase in the earnings base and the proposed speeding up of the scheduled increases in contribution rates for hospital insurance, the trust fund for that program would be depleted during fiscal 1973. As a result of the proposal to put into effect in 1971 the 0.9 percent hospital insurance contribution rate for workers and employers (each), now scheduled for 1987, and as a result of increasing the earnings base, the hospital insurance trust fund would grow to an estimated \$5.2 billion at the end of fiscal 1973.

On the other hand, the present schedule of contribution rates for old-age, survivors, and disability insurance would, even with substantial benefit increases, result in very large-scale growth in the size of the

trust funds for these parts of the social security program. Under present law the cash benefit trust funds would increase from an estimated \$38.7 billion at the end of the present fiscal year to about \$75 billion at the end of fiscal 1973. Under the President's proposal the trust funds would reach \$52.6 billion at the end of fiscal year 1973.

The postponement of the scheduled rate increases for the cash benefit parts of the social security program is consistent with past decisions by this Committee and the Congress to delay scheduled increases in the rates to avoid unnecessarily large increases in the cash benefit trust funds.

Overall, the combined contribution rates for both hospital insurance and cash benefits would be somewhat lower than the schedule in present law through 1976 and then the same from then on.

In summary the improvements we are recommending in social security today are substantial and important measures. We propose to bring benefit payments up to date and we propose to make sure that they stay up to date, automatically tied to the cost of living. We are also proposing important improvements in benefit protection for men workers and for widows and in other ways proposing to remove inequities in the system.

We are continuing to study all aspects of the social security program. The statutory Advisory Council on Social Security that I appointed in May is now conducting an extensive review of the social

security program, and we are looking to this Council for its recommendations on what further improvements might be made in the social security program. As the President said in his message on social security on September 25, "I emphasize that the suggested changes are only first steps, and that further recommendations will come from our review process."

Health Cost Effectiveness

Medicare and Medicaid have made major contributions over the past several years toward the availability of, quality of, and access to medical care for large numbers of people who are elderly or medically needy. The rising demands for medical care from the general population, combined with the newly created ability of the elderly and medically needy to financially compete for medical care, have placed great stress on inadequately and unevenly distributed manpower, facilities, and services. This has contributed to rapidly escalating medical care costs. Public and private action is needed to arrest the inflation in the health industry and to improve the health care system so that high quality medical care will be available at prices people can afford.

We are forwarding the Health Cost Effectiveness Amendments of 1969 today to continue efforts already taken to improve utilization of existing health service capability, encourage better planning, and achieve more effective cost control.

The main provisions would encourage voluntary and State planning for health facilities and provide greater authority and flexibility to engage in incentive reimbursement experiments to create incentives for efficiency and economy. They would also strengthen our ability to control some of the abuses of the programs.

These proposals, which can be discussed in greater detail by Commissioner Ball and Arthur Hess, Deputy Commissioner of Social Security and Staff Director of the Task Force on Medicaid and Related Programs, are addressed to the following specific items:

1. Tying depreciation payments to State health planning.
2. Making corporate planning a condition of participation.
3. Expanding authority for reimbursement experimentation.
4. Barring providers and physicians who abuse the program.
5. Paying customary charges if less than cost.
6. Withholding payments where utilization review finds admission is not warranted.
7. Improving authority to recover overpayments in Medicare.

Task Force on Medicaid and Related Programs

While both Medicare and Medicaid have moved toward achievement of their goals, their problems differ significantly. Medicare is operating on a firm program and administrative base, with its major problem being one of escalating medical costs and prices. Medicaid, on the other hand, in addition to the inflation problem, has experienced serious deficiencies in management resources. Difficulties

in administration nationally are exacerbated by complexities in the Federal-State relationships, wide variations in eligibility and scope of services, and unpredictability in covered, need for, and availability of services.

In recognition of the serious and growing problems under the Medicaid program and to assist the Department in making major efforts to strengthen and improve the current program, I appointed a Task Force on Medicaid and Related Programs in July, chaired by Walter J. McNerney. The Task Force is concerned both with problems that are amenable to short-range solutions through administrative action and with technical changes in the areas of management, effectiveness of use, cost and eligibility. It will also consider solutions that might require fundamental changes in legislation.

Structural reforms in the Medicaid program are being studied and may be necessary to assure health care services for low income families and individuals. However, there are some improvements that can be made in the short run to overcome some of the problems.

The Task Force has worked closely with Departmental staff and has kept me closely informed about the nature of possible short-range recommendations. Consistent with Task Force recommendations, the Department will be moving rapidly to strengthen the management and staffing of the title XIX program, to develop the necessary policies and regulations on standards and on utilization review, to encourage the development and implementation of adequate information systems and to provide technical assistance to the States. We expect

that some of the Task Force recommendations will produce legislative proposals to improve the Medicaid program and make service more efficient and economical for assistance recipients. We will, of course, submit our proposals for congressional consideration at the earliest possible moment.

Conclusion

Mr. Chairman, in this testimony I have outlined the legislative proposals to improve and strengthen our social security and public assistance programs, as well as proposals to help control health care costs. I strongly urge the enactment of these proposals.

Thursday, October 16, 1969

Statement of George Shultz, Secretary of Labor
Before the Committee on Ways and Means
on the Family Assistance Act of
1969

Mr. Chairman and members of the Committee, I am pleased to testify on the proposed Family Assistance Act, for I believe that it is one of the most far-reaching pieces of social legislation in this area in several decades.

Let me start by saying that this is not a proposal for a guaranteed minimum income. Work is a major feature of this program. This is a program of family assistance--for families with children--and is limited to that specific group.

The Family Assistance Plan is a composite program of work incentives, training and employment opportunities, child care and income allowances.

I believe very deeply, Mr. Chairman, that the time has come to start over on providing assistance to needy families. We should not be content to just mend AFDC; the record is clear that AFDC doesn't work.

The Family Assistance Plan is a new start.

I believe the changes we propose are consistent with the forward-looking changes made recently by this Committee with regard to training opportunities, and the treatment of earned income. Family Assistance, in a sense, builds on

the foundations already laid by recent amendments to AFDC.

My responsibility lies not with the whole of the Family Assistance plan, but with its relationships to the labor market. It is my concern that the program be structured in such a way as to protect work incentives, and that the program in its total design be one that creates the strongest possible conditions for moving people from welfare into employment.

Thus, I will discuss the way the allowance motivates people to work, the role of training opportunities in reducing welfare, the operation of registration and work requirements, and our expectations for providing the necessary employment opportunities within the regular economy.

WORK INCENTIVES AND THE FAMILY ASSISTANCE STRUCTURE

I have identified seven specific ways in which the Family Assistance Plan promotes work. I will summarize each of these briefly.

1. The incentive of welfare recipients to go to work has been increased by enlarging the income disregard and limiting the reduction of Family Assistance to one-half of earnings. Employed AFDC recipients retain only the first

\$30 of income plus one-third of earnings above that.

Family Assistance recipients will be able to keep the first \$60 of monthly earnings plus one-half of all income in excess of that amount.

The existence of a dual system in 40 States makes it necessary to compound tax rates to some extent so as to allow the States to reduce their supplemental payments as earnings increase.

However, the States would be directed to observe the same \$60 earnings disregard in computing the State supplement, so that State practices do not nullify those of Family Assistance. Also the States may subtract only 17 cents of the supplement for each dollar of wages above the \$60 disregard, bringing the total marginal tax rate on gross income to 67 cents on the dollar.

The disregard of the first \$60 of earnings is based on Labor Department surveys of the "cost of work." This is based on budget studies made by the Bureau of Labor Statistics of outlays made for added food, transportation, clothing and personal care, medical care, payroll deductions, and occupational needs such as tools, licenses, and union dues. These costs must be recouped before the individual realizes

any additional income from working.

The result is a double incentive. When a welfare recipient goes to work, his or her combined wages and Family Assistance increase, so there is always an incentive to work. On the other hand, as earnings increase, the government saves money because the Family Assistance payment is reduced. Thus, the government has an incentive to provide the necessary training and employment opportunities.

2. The extension of coverage to the working poor eliminates the situation where those who do not work receive higher incomes than those who work. The present welfare system excludes from coverage those who work regularly but at very low wages. This sometimes creates situations where some who work may have less income than others who do not work at all. To expect them to continue work under such circumstances is to expect individuals to behave in a manner adverse to their own economic interests. This is no way to assure the public interest.

3. The incentive of the working poor to seek higher wage levels is preserved. Since there rarely will be a

State supplement for men already at work (because most State systems do not cover the working poor), the tax on earnings will be limited to 50%. This means it will always pay an individual to increase his earnings. Also, the bill contemplates a program to upgrade the skills of the working poor so they may qualify for higher wages.

4. There is a financial incentive to enter manpower training programs. When a recipient enters training, the family will receive at least a \$30 increase in monthly income. If the allowance under the regular training program would be more than \$30 higher than Family Assistance payments (plus State supplement), the supplement to the Family Assistance trainee will be the difference between the two allowances. So, in most cases the financial incentive to take training will be in excess of \$30.

In the case of North Dakota, for example, Family Assistance plus the State supplement would equal \$188 a month for a family of four. However, since the Manpower Development and Training Act allowance in that State for the head of a family of four is \$255, the incentive payment would be \$67 per month--the difference between \$188 and \$255.

In addition to the incentive payment, persons taking training will be reimbursed for necessary expenses, such as transportation.

5. The child care provided in this Act itself will be a strong employment and training incentive. The lack of adequate child care arrangements often has been the major barrier to entering training programs or seeking employment. The fact that child care will not only be available, but will be of high quality, will permit mothers to look upon child care as an opportunity for their children as well as an opportunity for the mothers to become economically self sustaining.

It should be recognized that child care is an investment in not one, but in two generations. It is an investment in the present generation in the sense that it frees the mother for training or employment. It is an investment in the next generation because it provides the child an early education, quality care, and attention to health and other needs. In looking at child care costs (and it is expensive), this double effect should be borne in mind, and we should not "charge" all these costs to helping welfare mothers get work. Much of the return will be in the

kind of education we owe our young people anyway and in reduced welfare costs in the next generation.

We have a long way to go in creating adequate child-care provisions in the United States. Yet, there is no doubt that we are capable of providing it. We did in World War II. When the Kaiser shipyards hired Rosie the Riveter, they built child care centers for Rosie's children, and kept them open 24 hours a day. Yet at the present time, only about two percent of the children of working mothers are being cared for under group care arrangements.

6. The system of financial incentives will be buttressed by requirements that certain categories of recipients register for training and employment with the local manpower agency.

Every member of the family, with six exceptions specified in the law, are required to register with the Employment Service, and accept suitable employment. If a recipient refuses to register, or refuses suitable manpower services, training, or employment in which they are able to engage--without good cause--his portion of the Family Assistance payment will be denied. In such cases, the Secretary of HEW would continue to pay the remaining benefits to the rest of the family. Thus, the whole family will not be made to suffer.

7. An "Employability Plan" will be developed for those who register for training and employment. The bill would require that such a plan be developed for all who register, while recognizing the need to set priorities if the volume of registrations is sometimes greater than available resources. This means that the manpower agency will assess the needs of the individual, ascertain what manpower services are required by that person to become self supporting, and follow through until the individual completes the plan.

THE ROLE OF TRAINING IN REDUCING WELFARE

Clearly, the Work Incentive program provided by the 1967 amendments to the Social Security Act has established a foundation on which to build a larger training program in support of the Family Assistance Act.

In reviewing the experience with that program thus far, I want to begin by saying, quite candidly, that we have some problems.

One of the most difficult problems has been the provision of child care. Public day care arrangements are still very scarce, and we could increase enrollments in WIN quickly if more were available. Secretary Finch has already discussed this problem with you. We feel that it is a

problem that can be overcome. Doing so may require some innovative approaches.

While the State Employment Service has made considerable progress, there is much to be learned about the problems of disadvantaged individuals. The restructuring that is necessary for really efficient service is slowed by delays in training and retraining personnel. State salaries are frequently too low to attract and retain the most qualified people for this important and demanding work. And, as I will emphasize later, the WIN approach is the most sophisticated we have developed to date.

Our attempts to move quickly to establish WIN has resulted in some localities opening their doors before the programs were ready to serve their clients. But these kinds of problems are being overcome with time.

So far, there has been a lack of consistency among the policies of the State welfare agencies in deciding who is "appropriate" for referral. This has created wide differences among the States in the size of WIN training programs relative to their welfare populations. For example, in New York, only 7% of those screened by the welfare agency were deemed appropriate for referral to the Employment Service.

However, in Utah 97% of the assessments were considered appropriate for referral. The proposal removes the word "appropriate," in favor of specific exceptions, and thus removes this inequity. Furthermore, since referrals will be made by the Social Security Administration, rather than State welfare agencies, a consistent nationwide policy will be achieved.

Despite attempts to coordinate the job development efforts among different manpower programs, and within the WIN program itself, there are still inefficiencies in this process. As a result, the different programs run the danger of competing for the same pool of jobs, instead of expanding that pool. And employers become irritated at being approached so many different times. The passage of the Manpower Training Act will correct many of the basic structural problems inherent in operating many programs, instead of a single comprehensive program.

In spite of these start-up problems, the WIN program is operating at a substantial level. The program opened its doors in October of 1968, enrolling almost 6,000 people

in that month. Then it grew steadily, reaching an enrollment of 64 thousand persons by the end of August of this year. Achievement of our enrollment target of 150,000 by the end of fiscal 1970 will make WIN one of the largest of the manpower programs. On a cumulative basis, 92,000 persons had been enrolled through August.

We conducted a survey of 4,600 WIN participants who had completed the program in six States. The majority were employed in clerical and sales work, service, and production, assembly, and construction occupations. The rest were spread among a variety of occupations such as, for example, motor freight transportation, materials handling, machine trades, and processing occupations.

In the States surveyed, the median earnings were \$2.27 per hour. The median rate for men was \$2.47 per hour, and for women, \$2.02 per hour.

Effectiveness of training

The WIN program is young, for to date only 13,000 were employed following training. We cannot yet offer a firm judgment of success. However, we believe that it is a very promising program in concept and that its design is a rational one.

It provides a coherent cluster of services such as remedial medical attention, child care, job "coaches", orientation to the work world, basic education, job training, job counseling, placement, and intensive followup into employment.

All of these are fitted together in an individual employability plan, and by the team approach which brings all of the specialists together to serve a specific, assigned group of clients.

Most encouraging of all is the fact that mothers are volunteering for the WIN program, and that sanctions have been used for less than 200 persons. So far, none of them have been mothers.

Because of the importance of training to the goals of the Family Assistance Act, I would like to present this committee with the best information available on what can be expected from such training programs, by looking at the

experience of public assistance recipients trained under the Manpower Development and Training Act. About 24 thousand such recipients received training in 1968, and a total of 91 thousand were trained since the beginning of the MDTA program in 1963. MDTA provides a rough idea of what kind of success we will have under WIN.

Among public assistance recipients trained in 1967, 58 percent of those taking classroom training, and 72 percent of those receiving on-the-job training were in jobs at the time of follow-up surveys. Because WIN is a newer program with a broader range of coordinated supportive services, the success rate may be higher.

While the placement rates for public assistance trainees are lower than for others it is encouraging that public assistance recipients who did get jobs were receiving wages practically identical to those received by all MDTA trainees. In classroom training programs public assistance men earned \$2.21 per hour, compared to \$2.27 per hour for all graduates. And in the case of women, public assistance recipients earned \$1.74 per hour, compared to \$1.72 for all women graduates.

The wages were higher in on-the-job training, with public assistance men receiving \$2.36 per hour, and women \$1.80 per hour.

At even the lowest average wage, the \$1.74 per hour, a family of four would at least be lifted to the poverty line. Moreover, current wage levels are likely to be from 8 to 10 percent higher than those received by graduates in 1967.

This does not mean that training is always going to remove people from the welfare rolls. Some don't get jobs after training, in spite of our efforts to relate to it current labor market needs. Others obtain jobs at wages insufficient to fully remove them from poverty. And still others find better paying jobs but lose them for one reason or the other.

The basic point is that training can be a significant tool for reducing welfare, but it cannot by itself do the whole job, and it will not always work for all people.

The Expansion of Training

The potential of training is great enough to warrant

a considerable expansion under the Family Assistance Program. In announcing the program, the President stated that training would be expanded by 150,000 persons during the first full year of Family Assistance. This would be in addition to the increased training levels already planned for WIN. Also, a skill upgrading program will be initiated for 75,000 of the working poor.

Registration

The Family Assistance Act requires registration for manpower services, training and employment with the local public employment office of the State. Those exempt from this requirement are as follows:

- those ill, incapacitated, or of an advanced age
- a mother or other relative caring for a child under six
- the mother if the father or another adult male relative is in the home
- a child
- a person needed in the home to care for an ill member of the household
- those working full time

The groups excluded from mandatory referral may register voluntarily if they choose to. The penalty for failure to register without good cause is the denial of benefits, by the Secretary of Health, Education, and Welfare, based upon notification by the Secretary of Labor that a person has not registered. In such cases, arrangements will be made so that other family members will continue to receive their allowances.

Out of the 5 million family heads covered by Family Assistance, we estimate that 1.1 million will be required to register, and that 1.8 million will already be working full time. In addition, there will be a substantial number of voluntary registrations. We believe this latter group will consist mostly of mothers with pre-school children, based on our experience with WIN.

An employability plan will be developed for each person who registers, "in accordance with priorities prescribed" by the Secretary of Labor. Our objective will be to provide such an employability plan for every person who registers. However, where the number of training opportunities are limited--whether by the availability of funds, the inability to expand training at the rate needed, or limitations on how many persons the labor market can absorb--it will be necessary to assign priorities for which groups are served first.

Your question, I am sure, is how the Employment Service is going to serve such a large number of additional people. The answer is that some new approaches are going to be needed in the way the Employment Service conducts its business. We have plans to change the method of operation. In some cases trial runs are under way. In others, such trials will commence very soon. As of now we have three major steps in mind.

The first is to introduce computers into employment service operations just as fast as it can be done. The computer enables us to establish a "job bank" which provides a daily print-out of all the jobs that are reported. This is in operation right now in Baltimore, and has greatly accelerated the ability of the Employment Service to place disadvantaged persons. For example, placement of disadvantaged applicants increased by 250 percent in Baltimore because of the wider exposure of job opportunities via the Job Bank. Then we can move on to computer matching of the man and the job, a system now in use in Utah and Wisconsin.

Our target is to have 54 job banks installed yet this fiscal year. By the end of calendar year 1970, we expect to expand this to 76.

In the next year or two a new Employment Service Automated Reporting System will be installed. This will permit us to "track" individuals through the application - employability - placement process so that we can improve the system on the basis of facts rather than intuition.

The second is to organize the local employment service office in a way that will enable it to meet its traditional responsibilities for providing job assistance to those who are not poor, at the same time that it frees its resources to provide intensive assistance to those who have really serious employability problems. For the better equipped group of clients, there is going to have to be more "self-service," and we believe that the computer will enable us to provide this in such a way that these clients are well served, without requiring the staff time now being used.

This new operating arrangement, which has the support of the Inter-State Conference of Employment Security Agencies, has already been designed, and will be tested for about a year in six cities.

The third is to provide unemployment insurance claimants, who on the average are re-employed rather quickly, with more

job information directly from the U.I. office, and thus lighten the burden on the Employment Service. The unemployment insurance office could have the list of job openings from the job bank, and supply that information directly. The information itself, of course, would have to come from the Employment Service.

This is being tried in five cities this year, including Baltimore which has the job bank. We are requesting resources to make this new system operational in the 55 largest metropolitan areas in fiscal year 1971. These areas account for about half of the total U.I. caseload.

Beyond these specific improvements in the Employment Service, an improvement is planned in the entire Federal-State system of providing all manpower services, including training. That approach is incorporated in the Administration's Manpower Training Act, which is pending before another Committee. The manpower services provisions of this bill are written to parallel the Manpower Training Act, so that when both are passed we will have an integrated manpower delivery system.

Joint Task Force

The Family Assistance Act is a major legislative proposal that requires close working relationships between the Labor Department and the Department of Health, Education, and Welfare.

Unfortunately, our two Departments have not always worked together as smoothly as they should. The study made by the Legislative Reference Service of the enactment of WIN establishes this fact. There have been gaps in communication, and a history of competition for running the work training program.

Secretary Finch and I plan to have a maximum of coordination in the administration of these joint programs. To achieve this, we are establishing a joint HEW-Labor Task Force for the implementation and conduct of the programs we are responsible for.

This Task Force will assure a commonality of objectives, and develop joint guidelines, reporting procedures, and evaluation plans.

THE WORK TEST

A Family Assistance recipient will be denied benefits if he refuses "without good cause to accept suitable employment in which he is able to engage." He must also accept suitable training and manpower services.

The key word is "suitable." It is a test that has long been used in unemployment insurance, and over the years, through agency and court interpretation, a large body of case law has established its meaning in different situations.

We expect that a similar process will occur in the case of Family Assistance. It will be applied on an individual by individual basis, under guidelines that the Secretary of Labor will be responsible for providing to the State agencies. There will be appeals, and there will be hearings on those appeals. Cases may be taken to court where matters will finally be settled.

I can be somewhat more specific than this. We intend to follow the same policy with respect to wages as we now do in WIN, and in the proposed Manpower Training Act. We do not require a person to take a job that pays less than the applicable minimum wage, or the prevailing wage, whichever is higher.

But a policy of this sort does not contain the whole story. Our objective is to move people out of poverty and off welfare. We are not going to be out looking for low wage jobs. We want the highest wages possible. And to the maximum possible extent we are going to train people for jobs at decent wages, whenever we find that they cannot get good jobs with their present skills.

There is no intention of doing anything that would undermine existing wage levels. We are not going to open up a new cheap labor supply to employers who are not paying the going rate.

Having said this, I hasten to add that the labor market itself must be recognized as a constraint on the full achievement of our expectations. It is a fact that our economy has a lot of jobs that pay low wages. We are not going to be remaking the economy in this program. We have to relate to the labor market. We can only put people in the jobs that exist.

What this means is that we will have to thread our way between our goals of providing good jobs--after training when possible--and the realities of the kinds of jobs that are available.

Although Family Assistance relies primarily on incentives to work, it does include sanctions. These sanctions should be put into perspective.

By and large we expect that people will take jobs as we eliminate the barriers that have stood in the way of employment. Studies have shown that people on welfare are little different in their attitudes toward employment than persons not on welfare.

With the strong incentives to work that are built into the Family Assistance structure, I do not believe that it will be necessary to use sanctions very frequently. It is clear, even at present, that the AFDC population is not a static one. People are leaving the rolls every day for a variety of reasons, including taking jobs. Of the 600,000 who left the rolls during 1968, 37% departed because of increased earnings of someone in the home.

The denial of benefits in the Unemployment Insurance system because of refusal to accept suitable work is a relatively infrequent occurrence. In fiscal year 1969, less than .1 per cent of claimant contacts resulted in a disqualification from benefits due to refusal to accept suitable work.

There undoubtedly will be some who will refuse work in Family Assistance, despite the strong incentives which exist. It would not be fair to those who do work, or to the Nation's taxpayers, to allow them to choose idleness and a "free ride." A work requirement is not unreasonable as a condition of receiving Family Assistance benefits.

THE WORKING POOR

By and large, the programs that have been designed thus far to fight poverty have concentrated on the unemployed or families without a breadwinner. But this is not the full face of poverty. In the majority of poor families, where the head is under 65, the family head is working. Thus, the working sector harbors as much poverty as the non-working sector.

Who and where are the working poor?

-- half live in the South

-- over one out of three of the family heads have less than 8 years of education

-- over four out of ten of the family heads do not work full time, the year round

-- one out of three is black

The Family Assistance Act covers the working poor, and thereby includes them in the efforts of the Nation to eliminate poverty. Those who are employed and still poor will have their wages supplemented as well as those who are not able to work.

We estimate that among the population covered by the Family Assistance Act, there are 1.8 million family heads who work full time, for a full year, and still suffer the affliction of poverty. This is a larger number than those who do not work at all.

It is a group, we believe, that deserves the concern of the Nation and inclusion in the legislation which is before you.

RELIANCE ON THE REGULAR ECONOMY FOR JOBS

We believe that "work experience" programs, in which people are employed for temporary periods in public service jobs, are a useful component of a comprehensive manpower system. Such programs can be helpful in cases where there is no recent experience in employment by providing an opportunity to learn the demands of work.

It is not our intent to create jobs in the public sector especially for the hard-core unemployed as a way of solving manpower problems. We believe that such jobs are not a solution to employment problems, and represent instead a failure to face up to the more difficult task of equipping individuals to compete for the ever increasing number of real jobs that our economy is producing. We estimate that there will be 2 million job openings a year in clerical, sales, and operative occupations.

The problem, as we see it, is to remove people who can work from positions of economic dependence. We believe this means they should not have to depend on government supplying their work and their wages, just as much as it means that they should strive for independence from public welfare. A welfare job is no substitute for a welfare check.

Neither do we believe that public employment should be a basis for guaranteeing jobs. Government should assume a responsibility for maintaining a healthy economy that produces enough jobs, and commit itself to preparing people to fill those jobs. We want no work inventing system that offers a way around this basic responsibility.

In fact, regular public employment in State and local governments is increasing every year. We have launched

efforts to channel disadvantaged persons into those jobs, in much the same way that private employers are encouraged to hire and train such workers in the JOBS program run by the National Alliance of Businessmen. We are interested in developing more of these regular public jobs for the disadvantaged.

The Manpower Training Act provides authority for the kind of work projects that I have described. The Family Assistance Act, which is written to parallel the Manpower Training Act with regard to the services offered, also includes such authority. We intend to use it where it applies, in a context of moving people into regular jobs. But we do not expect it to be a major feature of the manpower program.

Mr. Chairman, these are the main points I wanted to make in my formal statement.

We recognize that this new departure in welfare will require a substantial initial investment. But we believe that a transformed system will set in motion forces that will lessen dependency and foster economic growth. These substantial "start up" costs now will ultimately cost us

less as a Nation, both in terms of dollars expended and lives wasted and warped.

This program has had the benefit of extended analysis and discussion, at the highest levels, and throughout the Administration. We feel we are right about the need to reform welfare, and the directions we have chosen. As we remove the barriers to employment through training and child care programs, and as we build work incentives into the allowance structure--and remove the disincentives--welfare people will go to work and the upward spiral of costs will be reversed.

Through the centuries our social policies have become much more humane, but whatever the purity of our intentions, actions have often been perverse, with a tendency to punish as well as protect. The right to life for all our citizens is a matter that calls for our best effort, and our most considered judgment.

I recall to you the opening words of the President's message, that "A measure of the greatness of a powerful nation is the character of the life it creates for those who are powerless to make ends meet."

SOCIAL SECURITY CHARTS



1969 LEGISLATIVE RECOMMENDATIONS

67

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration

OCTOBER 1969

LEGISLATIVE CHARTS

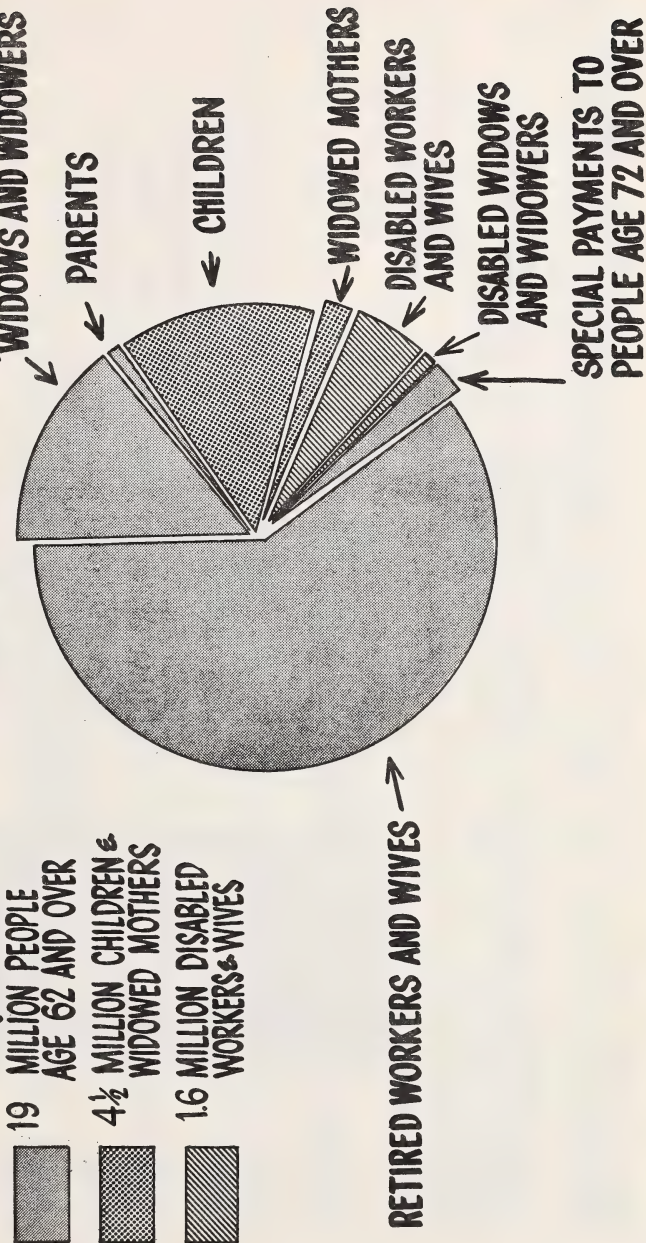
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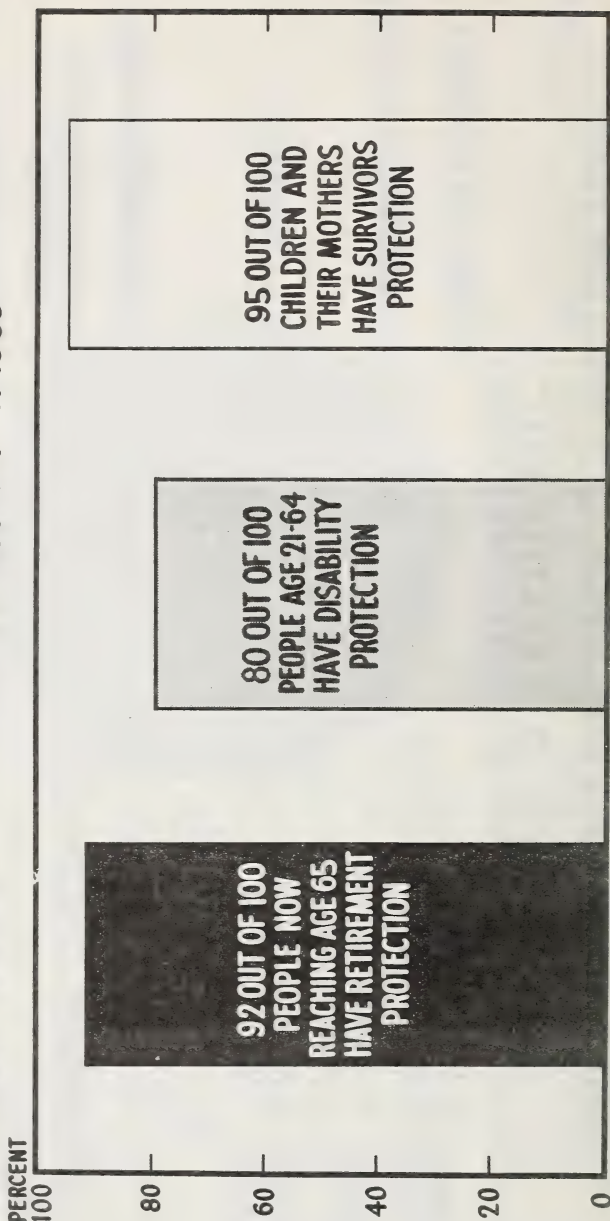
SOCIAL SECURITY PROPOSALS

1. 10% BENEFIT INCREASE
2. INCREASE IN EARNINGS BASE TO \$9000
3. ELIMINATION OF WORK DISINCENTIVES IN THE RETIREMENT TEST
4. FUTURE AUTOMATIC ADJUSTMENT OF BENEFITS, EARNINGS BASE,
AND RETIREMENT TEST
5. INCREASE IN WIDOW'S BENEFITS
6. AGE-62 COMPUTATION POINT FOR MEN
7. ADDITIONAL DEPENDENTS' BENEFITS AND NONCONTRIBUTORY WAGE CREDITS
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8. COST CONTROL AMENDMENTS FOR HEALTH BENEFITS
9. RESTORATION OF ACTUARIAL BALANCE OF HOSPITAL INSURANCE PROGRAM
10. MODIFICATION IN CONTRIBUTION RATE SCHEDULES

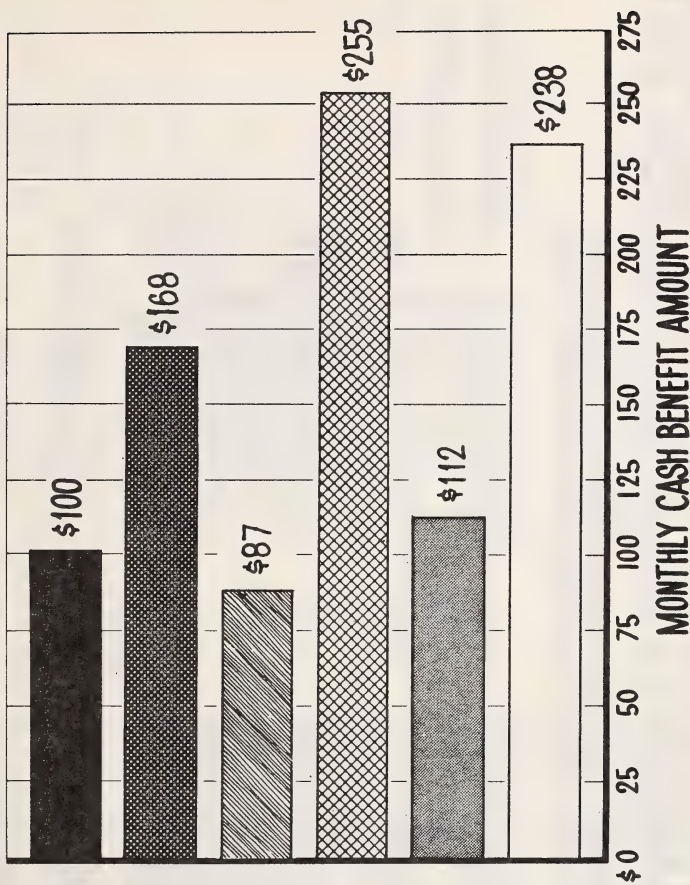
HIGHER BENEFITS FOR OVER 25 MILLION PEOPLE (1 OUT OF 8 AMERICANS)



INCREASED SOCIAL SECURITY PROTECTION FOR NEARLY ALL WORKERS AND THEIR FAMILIES -- 92 MILLION WORKERS WILL CONTRIBUTE TO SOCIAL SECURITY IN 1969

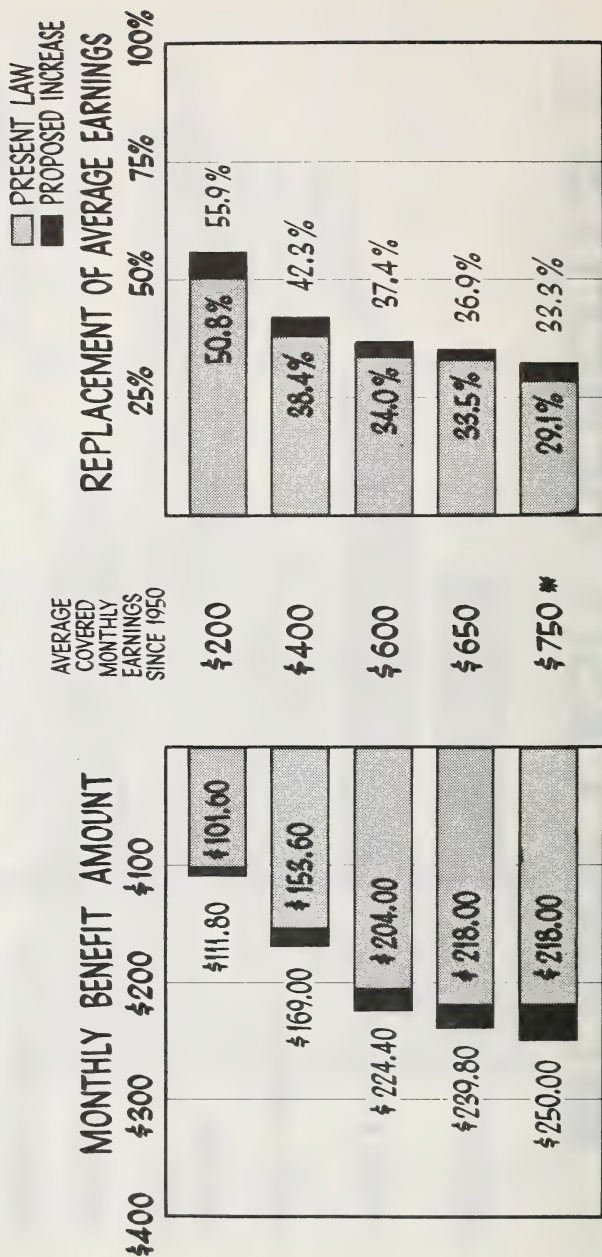


AVERAGE CASH BENEFITS*



*UNDER PRESENT LAW

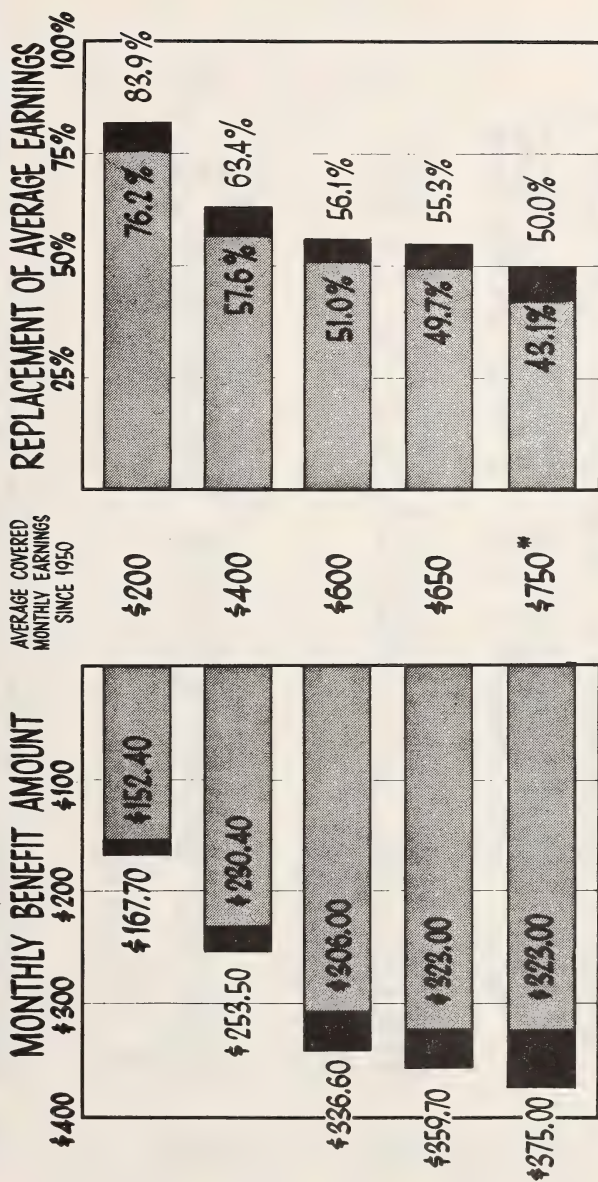
BENEFIT AMOUNTS INCREASED 10 PERCENT FOR A WORKER AGE 65



* MAXIMUM ANNUAL EARNINGS COUNTED — \$9000

BENEFIT AMOUNTS INCREASED 10% FOR A COUPLE AGE 65

 PRESENT LAW
 PROPOSED INCREASE

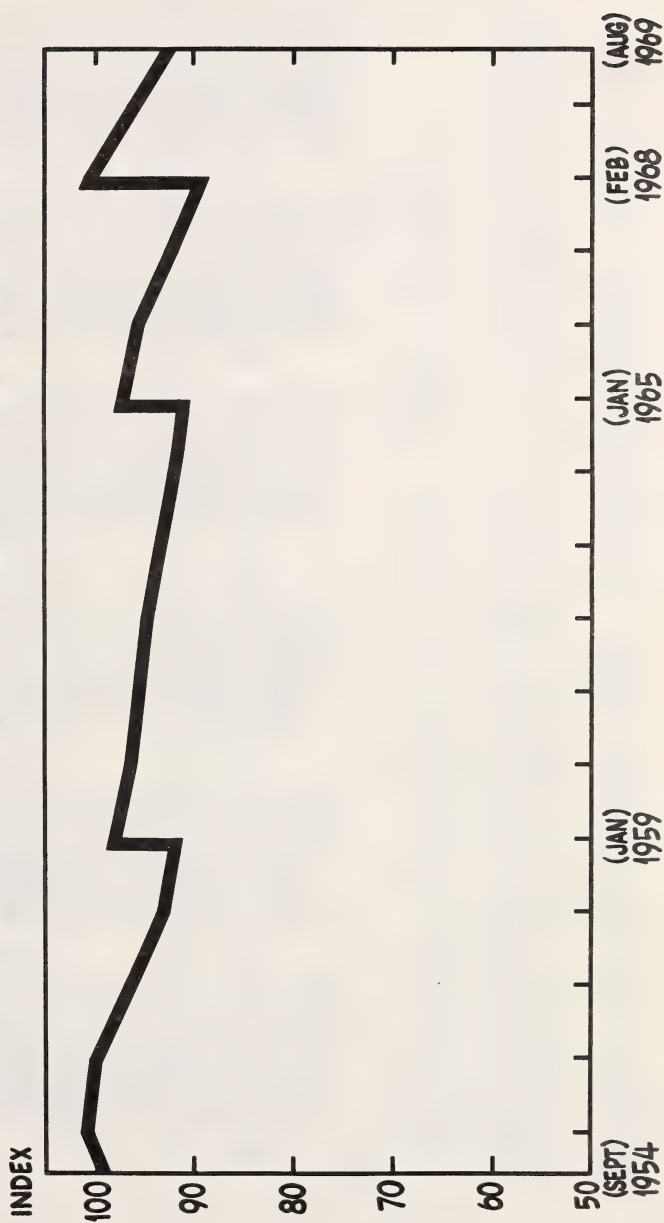


* MAXIMUM ANNUAL EARNINGS COUNTED - \$9000

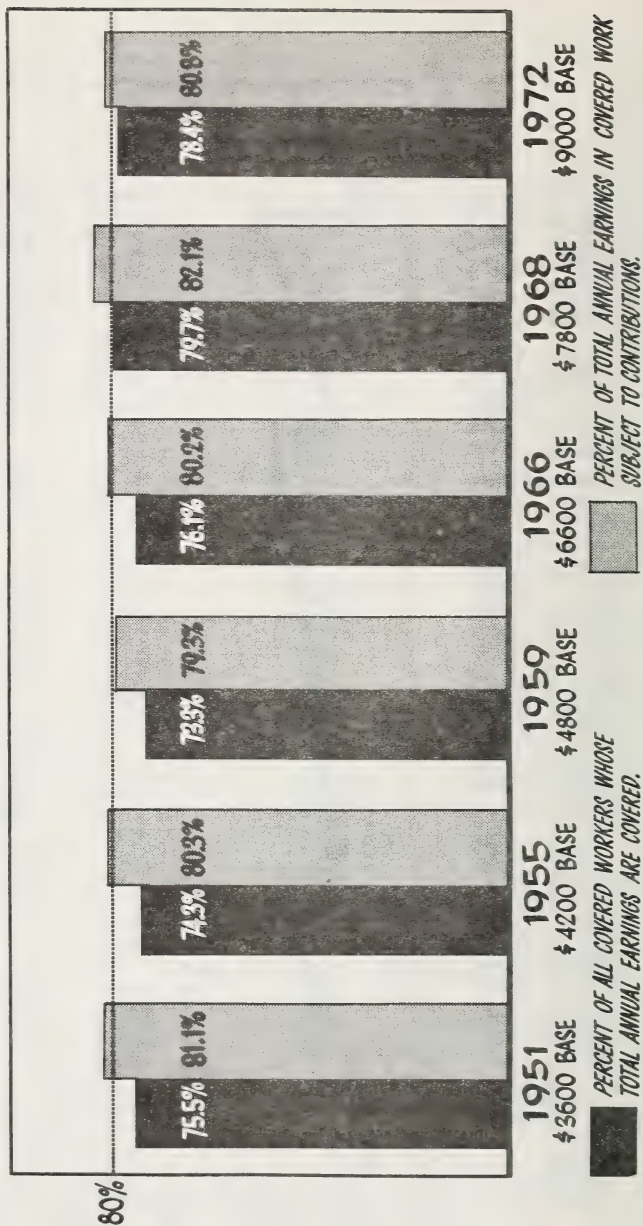
AUTOMATIC ADJUSTMENT OF BENEFITS TO PRICES

- 1. WHEN THE CPI INCREASES AT LEAST
3 PERCENT**
- 2. BUT NO MORE OFTEN THAN ONCE
A YEAR**
- 3. INCREASES EFFECTIVE FOR
JANUARY, BEGINNING WITH 1971**

DECLINE IN REAL VALUE OF BENEFITS SINCE 1954 DUE TO LAG IN BENEFIT INCREASES



\$9000 CONTRIBUTION AND BENEFIT BASE IN 1972 MAINTAINS RELATIONSHIP OF BASE TO EARNINGS LEVELS



AUTOMATIC ADJUSTMENT OF MAXIMUM EARNINGS COUNTED

**1. MAXIMUM INCREASED BY PERCENTAGE INCREASE IN
AVERAGE WAGES, ROUNDED TO NEAREST \$600**

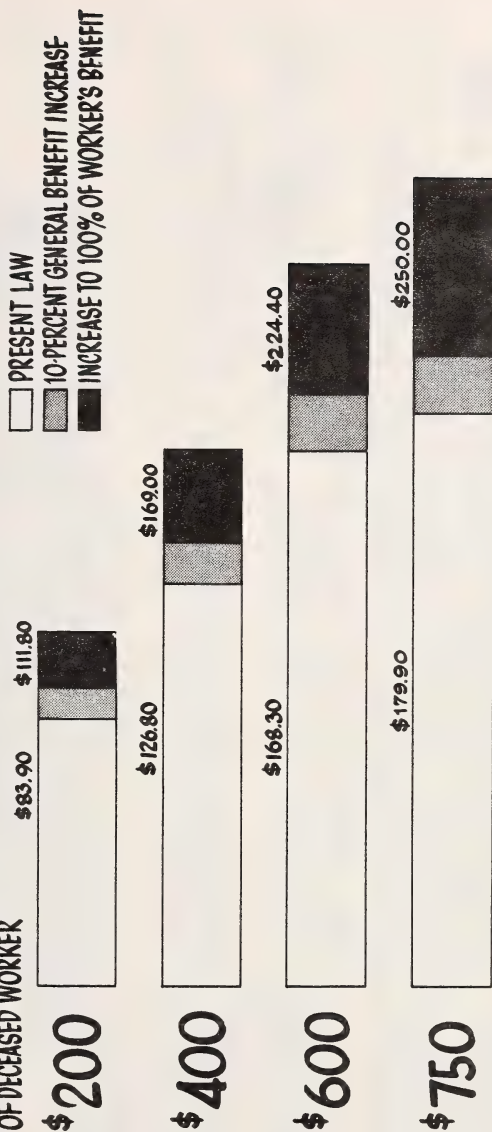
**2. INCREASE LIMITED TO EVERY TWO YEARS,
BEGINNING WITH 1974**

ELIMINATING WORK DISINCENTIVES IN THE RETIREMENT TEST

	PRESENT	PROPOSED
ANNUAL EXEMPT AMOUNT	\$1680	\$1800
\$1-for-\$2 ADJUSTMENT	\$1680 -\$2880	Above \$1800
\$1-for-\$1 ADJUSTMENT	Above \$2880	_____
MONTHLY MEASURE	\$140	\$150

WIDOW'S BENEFIT AT AGE 65 INCREASED TO 100% OF WORKER'S BENEFIT*

AVERAGE MONTHLY EARNINGS
OF DECEASED WORKER



* INCLUDES THE EFFECT OF THE HIGHER BENEFITS PAYABLE ON THE HIGHER EARNINGS THAT ARE CREDITABLE UNDER THE BILL

BENEFIT COMPUTATION UNDER PRESENT LAW

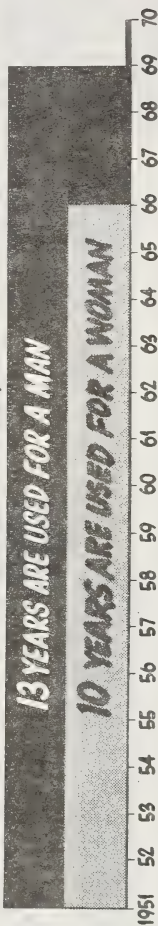
BENEFITS BASED ON AVERAGE MONTHLY EARNINGS FIGURED OVER A NUMBER OF YEARS EQUAL TO 5 LESS THAN THE NUMBER OF YEARS

AFTER
1950 OR
AGE 21

UP TO THE YEAR OF
AGE 65 FOR MEN
AGE 62 FOR WOMEN

EXAMPLE:

AGE 65 IN 1969



BENEFIT ELIGIBILITY ALSO FIGURED

UP TO AGE 65 FOR A MAN

UP TO AGE 62 FOR A WOMAN

OTHER IMPROVEMENTS IN SOCIAL SECURITY PROTECTION

- **EXTEND CHILDHOOD DISABILITY BENEFITS TO
PEOPLE DISABLED BETWEEN AGES 18 AND 22**
- **EXTEND NONCONTRIBUTORY WAGE CREDITS FOR
MILITARY SERVICE TO THE PERIOD JAN.1957 TO DEC.1967**
- **EXTEND BENEFITS TO DEPENDENT PARENTS OF
RETIRED AND DISABLED BENEFICIARIES**

AMENDMENTS AFFECTING HEALTH BENEFIT COSTS

1. Tie depreciation payments to State health planning .
2. Make corporate planning a condition of participation .
3. Expand authority for reimbursement experimentation .
4. Bar providers and physicians who abuse the program .
5. Pay customary charges if less than cost .
6. Withhold payment where UR finds admission not warranted .
7. Authority to estimate overpayments for recoupment .

STATUS OF THE CASH-BENEFITS TRUST FUNDS

ACTUARIAL BALANCE (PERCENT OF PAYROLL)	
AFTER 1967 AMENDMENTS (FEB. 1968)	+0.01%
1969 TRUSTEES' REPORT (JAN. 1969)	+0.53
REVISED COST ESTIMATE (SEPT. 1969)	+1.16

STATUS OF THE HOSPITAL INSURANCE TRUST FUND

ACTUARIAL BALANCE
(PERCENT OF PAYROLL)

+ 0.03%

AFTER 1967 AMENDMENTS (FEB. 1968)

- 0.29

1969 TRUSTEES' REPORT (JAN. 1969)

- 0.77

REVISED COST ESTIMATE (SEPT. 1969)*

CONTRIBUTION RATES FOR EMPLOYEES AND EMPLOYERS

YEAR	CASH BENEFITS		HOSPITAL INSURANCE		TOTAL	
	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL
1970	4.2 %	4.2 %	0.60 %	0.6 %	4.80 %	4.8 %
1971-72	4.6	4.2	0.60	0.9	5.20	5.1
1973-74	5.0	4.2	0.65	0.9	5.65	5.1
1975	5.0	4.6	0.65	0.9	5.65	5.5
1976	5.0	4.6	0.70	0.9	5.70	5.5
1977-79	5.0	4.8	0.70	0.9	5.70	5.7
1980-86	5.0	4.9	0.80	0.9	5.80	5.8
1987 & AFTER	5.0	5.0	0.90	0.9	5.90	5.9

ESTIMATED PROGRESS OF THE HOSPITAL INSURANCE TRUST FUND

Under Present Law and under Proposal, 1970-1973

(In Billions)

FISCAL YEAR	INCOME		OUTGO		NET INCREASE IN FUNDS	
	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL
1970	\$5.5	\$5.5	\$5.3	\$5.3	\$0.2	\$0.2
1971	5.9	7.1	6.3	6.3	-0.5	0.7
1972	6.0	8.7	7.4	7.4	-1.5	1.2
1973	6.3	9.6	8.6	8.6	-2.2	1.0

ESTIMATED PROGRESS OF THE CASH-BENEFITS TRUST FUNDS

Under Present Law and under Proposal, 1970-1973

(In Billions)

FISCAL YEAR	INCOME		OUTGO		NET INCREASE IN FUNDS	
	PRESENT LAW	PROPOSAL	PRESENT LAW	PROPOSAL ^{1/}	PRESENT LAW	PROPOSAL
1970	\$ 35.2	\$ 35.2	\$ 28.4	\$ 29.1	\$ 6.8	\$ 6.1
1971	38.6	36.8	29.6	32.9	8.9	3.9
1972	43.1	39.3	30.8	35.4	12.3	3.9
1973	47.4	43.4	32.0	36.5	15.4	6.8

1/ ASSUMES NO AUTOMATIC INCREASES IN BENEFITS UNDER THE COST-OF-LIVING PROVISION

FINANCING HOSPITAL INSURANCE BENEFITS

PRESENT PROGRAM*

PROPOSALS:

CONTRIBUTION BASE

AUTOMATIC ADJUSTMENT OF BASE

CONTRIBUTION RATES

PROPOSED PROGRAM

PERCENT OF PAYROLL		
LEVEL COST OF BENEFITS	LEVEL EQUIVALENT OF INCOME	BALANCE
2.27	1.50	-0.77
-0.17		
-0.39		
	0.27	
1.71	1.77	+0.06

* Preliminary

FINANCING SOCIAL SECURITY CASH BENEFITS

PERCENT OF PAYROLL		
	LEVEL COST OF BENEFITS	LEVEL EQUIVALENT OF INCOME
PRESENT PROGRAM	8.72	9.88
PROPOSALS ^{1/}		
CONTRIBUTION BASE	- 0.23	
BENEFIT INCREASE	0.79	
WIDOW'S BENEFITS	0.25	
AGE-62 COMPUTATION POINT FOR MEN	0.10	
RETIREMENT TEST LIBERALIZATION	0.08	
OTHER IMPROVEMENTS	0.01	
CONTRIBUTION RATE POSTPONEMENT		- 0.25
PROPOSED PROGRAM	9.72	9.63
		- 0.09
		+ 1.16

^{1/}VARIOUS AUTOMATIC ADJUSTMENT FEATURES AS A WHOLE DO NOT INCREASE THE COST OF THE PROGRAM AS A PERCENT OF PAYROLL.

ADDITIONAL PAYMENTS IN FIRST FULL CALENDAR YEAR AND NUMBER OF PEOPLE AFFECTED

PROVISION	ADDITIONAL PAYMENTS (IN MILLIONS)	BENEFICIARIES IMMEDIATELY AFFECTED (IN THOUSANDS)	NEWLY ELIGIBLE PEOPLE (IN THOUSANDS)
10 % BENEFIT INCREASE	\$ 2,997	25,500	12 ^{1/}
MODIFICATION OF RETIREMENT TEST	350	800	300 ^{2/}
AGE-62 COMPUTATION POINT	392	5,000	100
INCREASE IN WIDOW'S BENEFITS	610	2,700	--
OTHER IMPROVEMENTS	62	150	38
TOTAL	<u>\$4,411</u>	(3 ^{1/})	(3 ^{1/})

^{1/} NONINSURED PEOPLE AGED 72 AND OVER WHO CAN NOT GET BENEFITS UNDER PRESENT LAW.

^{2/} PEOPLE WHO CAN GET NO BENEFITS FOR 1971 UNDER PRESENT LAW BUT WHO WOULD GET SOME BENEFITS UNDER THE PROPOSAL.

^{3/} FIGURES ARE NOT ADDITIVE BECAUSE TIME PERIODS ARE NOT UNIFORM AND BECAUSE A PERSON MAY BE AFFECTED BY MORE THAN ONE PROVISION.

Report of the Committee on
Ways and Means, House of
Representatives to Accompany
H. R. 15095, Social Security
Amendments of 1969, House of
Representatives, Report No.
91-700

SOCIAL SECURITY AMENDMENTS OF 1969

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 15095



DECEMBER 5, 1969.—Committed to the Committee of the Whole House
on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

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SOCIAL SECURITY AMENDMENTS OF 1969

DECEMBER 5, 1969.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLS, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 15095]

The Committee on Ways and Means, to whom was referred the bill (H.R. 15095) to increase benefits under the old-age, survivors, and disability insurance program, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. PURPOSE OF THE BILL

The purpose of H.R. 15095 is to provide an across-the-board increase in social security benefits of 15 percent for the 25 million elderly people, disabled people and their dependents, and widows and orphans who now get monthly social security benefits. In addition, the increase would apply to those people who will come on the benefit rolls in the future.

II. DISCUSSION OF THE PROVISIONS OF THE BILL

On October 15, the Committee on Ways and Means held extensive public hearings on all aspects of the Social Security Act, including the old-age, survivors, and disability insurance program, the public assistance programs, and the medicare and medicaid programs. As the evidence presented at these hearings unfolded, it became obvious that there was a pressing and urgent need for an across-the-board increase in the social security payments of people now on the benefit rolls. The information supplied to your committee indicated that the need was such that the increase should be provided as quickly as possible. Moreover, a recent revision in the long-range cost estimates of the system showed for the old-age, survivors, and disability programs an actuarial surplus of 1.16 percent of taxable payroll—an amount sufficient to meet

the cost of a 15-percent benefit increase. Therefore, your committee unanimously recommends that social security benefits be increased by 15 percent, effective with the benefits payable for January 1970. The benefit increase will be reflected in the checks issued on April 13, 1970, as is further explained below.

Your committee is convinced of the necessity to consider without unnecessary delay the many issues affecting the various programs under the Social Security Act which may call for legislative modification, and it intends to continue consideration of these issues as its first order of business when the Congress reconvenes next year. At that time, your committee will continue its consideration of the President's social security and welfare recommendations along with other proposals relating to public assistance and social security, including the operation of the medicare and medicaid programs. However, your committee does not believe the 15-percent benefit increase for social security beneficiaries should be delayed pending the committee's consideration of these other matters.

Number of persons affected: Your committee's bill would provide increased payments to the more than 25 million beneficiaries who will be on the benefit rolls in January 1970. Your committee has been informed that additional payments in fiscal year 1970 would total \$1.7 billion, and that payments in the first full calendar year in which the increased benefits are paid—1971—would total \$4.4 billion.

Minimum, and maximum benefit changes: Under the bill, the minimum benefit for a retired worker coming on the benefit rolls at or after age 65, and for a disabled worker, would be increased from \$55 to \$64 per month. The maximum worker's benefit would be increased from \$218 to \$250.70. (Although this maximum benefit is not payable until the year 2006 to people retired at age 65, maximum benefits are possible earlier for disabled people and for survivor families.)

Special age 72 benefits also increased: The special payments for certain people aged 72 and older who either have not worked at all under social security or have not worked long enough to qualify for regular social security cash benefits would also be increased by 15 percent—from \$40 for an individual and from \$60 for a couple to \$46 and \$69, respectively.

Effective date: Because of the time required to make the necessary changes in the Social Security Administration records and procedures that are needed to pay the new, higher amounts, the first check which could reflect the new rates would be for next March, payable in April. In addition, a separate check covering the retroactive increase for the January and February payments would be paid in April.

The following table shows illustrative benefit amounts under present law and under the proposed increase :

Average monthly earnings	Worker ¹		Man and wife ^{1 2}		Widow, widower, or parent, age 62	
	Present law	Bill	Present law	Bill	Present law	Bill
Minimum ³	\$55. 00	\$64. 00	\$82. 50	\$96. 00	\$55. 00	\$84. 00
\$150.....	88. 40	101. 70	132. 60	152. 60	73. 00	83. 90
\$250.....	115. 00	132. 30	172. 50	198. 50	94. 90	109. 20
\$350.....	140. 40	161. 50	210. 60	242. 30	115. 90	133. 30
\$450.....	165. 00	189. 80	247. 50	284. 70	136. 20	156. 60
\$550.....	189. 90	218. 40	284. 90	327. 60	156. 70	180. 20
\$650.....	218. 00	250. 70	323. 00	⁴ 376. 10	179. 90	206. 90

¹ For a worker who is disabled or who is age 65 or older at the time of retirement and a wife age 65 or older at the time when she comes on the rolls.

² Survivor benefit amounts for a widow and 1 child or for 2 parents would be the same as the benefits for a man and wife, except that the total benefits would always equal 150 percent of the worker's primary insurance amount; it would not be limited to \$323 as it is under the present law.

³ Average monthly earnings of \$74 or less under the present law, and of \$76 or less under the bill.

⁴ \$105 limit on wife's benefit is removed.

III. ADDITIONAL AMENDMENTS RELATED TO THE 15-PERCENT BENEFIT INCREASE

In order to assure that all beneficiaries would get the 15-percent increase, the \$105 monthly limit in present law on the wife's, husband's, and certain remarried widow's and widower's benefits would be removed. Also, as has been true whenever there have been benefit increases in the past, the bill would permit families already on the rolls to get the 15-percent increase for January and succeeding months even though payments to such families exceed the maximum limit on family benefit payments for their particular average monthly wage.

Because H.R. 15095 increases disability insurance benefits by 15 percent—which are paid out of the disability insurance trust fund—your committee would provide a 15-percent increase in the allocation of social security tax income to the disability insurance trust fund. Beginning in 1970, the allocation to the trust fund would be increased from 0.95 percent of taxable wages to 1.1 percent of taxable wages and from 0.7125 percent of taxable self-employment income to 0.825 percent of taxable self-employment income.

Under present law the disability insurance trust fund is in approximate actuarial balance, having a long-range balance of -0.01 percent of taxable payroll. The old-age and survivors insurance trust fund has a substantial positive balance, amounting to 1.17 percent of taxable payroll. The increase in the allocation of contribution income to the disability insurance trust fund will meet the cost of the 15-percent benefit increase provided under the bill for disability beneficiaries and keep the disability insurance trust fund in actuarial balance, while leaving the old-age and survivors insurance trust fund in approximate actuarial balance.

IV. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The old-age, survivors, and disability insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is very closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by your committee's bill shows an actuarial balance of -0.08 percent of taxable payroll under the intermediate-cost estimate. This is, of course, very close to an exact balance, especially considering that a range of variation is necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by your committee's bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows exact actuarial balance under the provisions that would be in effect after enactment of your committee's bill, because the contribution rate allocated to this fund is exactly the same as the cost of the disability benefits based on the intermediate-cost estimate. Accordingly, the disability insurance program, as it would be modified by your committee's bill, is actuarially sound.

(b) Contribution rate schedule for old-age, survivors, and disability insurance in bill

The contribution schedule for old-age, survivors, and disability insurance in present law is not changed by your committee's bill.

These tax schedules are as follows:

[Percent]			
Calendar year		Combined employer-employee rate	Self-employed rate
1969-70.....		8.4	6.3
1971-72.....		9.2	6.9
1973 and after.....		10.0	7.0

The allocated rates to the two trust funds that are applicable to the combined employer-employee contribution rate for your committee's bill, as compared with present law, are as follows:

[Percent]				
Calendar year	Old-age and survivors insurance		Disability insurance	
	Present law	Committee bill	Present law	Committee bill
1970.....	7.45	7.30	0.95	1.10
1971-72.....	8.25	8.10	.95	1.10
1973 and after.....	9.05	8.90	.95	1.10

The allocation for disability insurance with respect to the self-employed rate is increased from 0.7125 percent under present law to 0.825 percent under your committee's bill.

(c) Actuarial balance of program after enactment of 1967 act

The changes made by the 1967 amendments involved an increased cost that was fully met by the accompanying changes in the financing provisions (namely, an increase in the contribution rates in 1973 and after and an increase in the earnings base). After an increase in the allocation to the disability insurance system, both that portion of the program and the old-age and survivors insurance portion were estimated to be in close actuarial balance.

In 1968 the cost estimates were completely revised, based on the availability of new operating data. The new estimates showed significantly lower costs. The actuarial balance of the old-age, survivors, and disability insurance program increased from +0.01 percent of taxable payroll to +0.53 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1968 earnings assumption (instead of 1966 earnings) +0.33 percent; (2) use of 41¼ percent interest assumption (instead of 3¾ percent), +0.11 percent; (3) use of higher female labor force participation rates, +0.06 percent; and (4) other factors, +0.02 percent.

Then, in 1969, another complete revision of the actuarial cost estimates was made. The estimated cost of the program was again significantly reduced. The actuarial balance of the old-age, survivors, and disability insurance program was thereby increased from the figure of +0.53 percent of taxable payroll according to the 1968 estimate to +1.16 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1969 earnings assumption (instead of 1968 earnings), +0.22 percent; (2) use of 4¾-percent interest assumption (instead of 41¼ percent), +0.11 percent; (3) use of higher labor force participation rates, for both men and women, +0.23 percent; and (4) other factors, +0.07 percent.

(d) Actuarial balance of OASDI system

According to the latest cost estimates made for the 1967 act, there is a very favorable actuarial balance for the combined old-age, survivors, and disability insurance system, but that there is a deficit of 0.01 percent of taxable payroll for the disability insurance portion, and a favorable balance of 1.17 percent of taxable payroll for the old-age and survivors insurance portion.

Under your committee's bill, the benefit changes proposed would be financed by utilizing the existing favorable actuarial balance, without any increases in the contribution rates and the earnings base. Accordingly, since the disability insurance system is in such close actuarial balance under existing law, it is necessary to increase the portion of the combined contributions which are allocated to it, so as to finance the cost of the 15-percent benefit increase. Under the new allocation basis, both the old-age and survivors insurance system and the disability insurance system are in close actuarial balance.

Table I traces through the change in the actuarial balance of the system from its situation under present law, according to the latest estimate, to that under your committee's bill, by type of major changes involved, determined as of January 1, 1970.

TABLE I.—CHANGES IN ACTUARIAL BALANCE OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, BY TYPE OF CHANGE, INTERMEDIATE-COST ESTIMATE, PRESENT LAW AND COMMITTEE BILL

[Percent]			
Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	+1.17	-0.01	+1.16
Benefit increase of 15 percent	-1.10	-.14	-1.24
Revised allocation of contribution rate	-.15	+.15	.00
Total effect of changes in bill	-1.25	+.01	-1.24
Actuarial balance under bill	-.08	.00	-.08

The changes made by your committee's bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance system. The estimated actuarial balance of -0.08 percent of taxable payroll is inside the established limit within which the system is considered substantially in actuarial balance.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(e) Level-costs of benefit payments, by type

The level-cost of the old-age and survivors insurance benefit payments (without considering administrative expenses, the railroad retirement financial interchange, and the effect of interest earnings on the existing trust fund) under the 1967 act, according to the latest intermediate-cost estimate, is 7.82 percent of taxable payroll, and the corresponding figure for the program as it would be modified by your committee's bill is 8.92 percent. The corresponding figures for the disability benefits are 0.96 percent for the 1967 act and 1.10 percent for your committee's bill.

Table II presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of your committee's bill, separately for each of the various types of benefits.

TABLE II.—ESTIMATED LEVEL-COST OF BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, AFTER ENACTMENT OF COMMITTEE BILL, AS PERCENTAGE OF TAXABLE PAYROLL,¹ BY TYPE OF BENEFIT, INTERMEDIATE-COST ESTIMATE

[Percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits.....	6.16	0.90
Wife's and husband's benefits.....	.50	.06
Widow's and widower's benefits.....	1.30	(2)
Parent's benefits.....	.01	(2)
Child's benefits.....	.74	.14
Mother's benefits.....	.13	(2)
Lump-sum death payments.....	.08	(2)
Total benefits.....	8.92	1.10
Administrative expenses.....	.13	.04
Railroad retirement financial interchange.....	.07	.00
Interest on existing trust fund ³	-.26	-.04
Net total level-cost.....	8.86	1.10

¹ Including adjustment to reflect the lower contribution rate on self-employment income and on tips, as compared with the combined employer-employee rate.

² This type of benefit is not payable under this program.

³ This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

(f) *Income and outgo in near future*

Under your committee's bill, benefit disbursements under the old-age, survivors, and disability insurance system will increase by \$1.7 billion in fiscal year 1970 over present law; this represents the increase for 5 months' of benefit payments—since the increase is first effective for January 1970.

Under the program as modified by your committee's bill, according to this estimate, the old-age and survivors insurance trust fund will increase by about \$1.6 billion in 1970. In 1971-72, the trust fund will increase by about \$5 billion per year. In the next 2 years, as a result of the scheduled increase in the contribution rates in 1973, the trust fund will increase by about \$11 billion each year. Table III presents these short-range estimates.

TABLE III.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Contribu- tions	Benefit payments	Admini- strative expenses	Railroad retirement financial inter- change ²	Interest on fund ¹	Balance in fund at end of year ³
Actual data:						
1951	\$3,367	\$1,885	\$81	-----	\$417	\$15,540
1952	3,819	2,194	88	-----	365	17,442
1953	3,945	3,006	88	-----	414	18,707
1954	5,163	3,670	92	-\$21	447	20,576
1955	5,713	4,968	119	-7	454	21,663
1956	6,172	5,715	132	-5	526	22,519
1957	6,825	7,347	162	-2	556	22,393
1958	7,566	8,327	194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
1965	16,017	16,737	328	436	593	18,235
1966	20,658	18,267	256	444	644	20,570
1967	23,216	19,468	406	508	818	24,222
1968	24,101	22,642	476	438	939	25,704
Estimated data (short-range estimate), committee bill:						
1969 ⁴	28,523	24,245	469	491	1,139	30,161
1970	30,089	28,799	516	526	1,352	31,761
1971	34,527	30,288	532	564	1,562	36,466
1972	36,455	31,414	551	633	1,872	42,195
1973	41,429	32,518	571	621	2,308	52,222
1974	43,459	33,641	591	612	2,870	63,707

¹ An interest rate of 4.75 percent is used in determining the level costs, under the intermediate-cost long-range estimates, but in developing the progress of the trust fund a varying rate in the early years has been used.

² A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

³ Not including amounts in the railroad retirement account to the credit of the old-age and survivors insurance trust fund. In millions of dollars, these amounted to \$377 for 1953, \$284 for 1954, \$163 for 1955, \$60 for 1956, and nothing for 1957 and thereafter.

⁴ Estimated data for present law.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service and for the special benefits payable to certain noninsured persons aged 72 or over.

The disability insurance trust fund is estimated to increase by about \$1.4 billion in 1970 under your committee's bill, and by somewhat larger amounts each year thereafter for the next few years. Table IV presents these short-range estimates.

TABLE IV.—PROGRESS OF DISABILITY INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]						
Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange ¹	Interest on fund ²	Balance in fund at end of year
Actual data:						
1957.....	\$702	\$57	\$3	-----	\$7	\$649
1958.....	966	249	12	-----	25	1,379
1959.....	891	457	50	—\$22	40	1,825
1960.....	1,010	568	36	—5	53	2,289
1961.....	1,038	887	64	5	66	2,437
1962.....	1,046	1,105	66	11	68	2,368
1963.....	1,099	1,210	68	20	66	2,235
1964.....	1,154	1,309	79	19	64	2,047
1965.....	1,188	1,573	90	24	59	1,606
1966.....	2,022	1,784	137	25	58	1,739
1967.....	2,302	1,950	109	31	78	2,029
1968.....	3,454	2,294	127	20	106	3,025
Estimated data (short-range estimate), committee bill:						
1969 ³	3,643	2,563	151	21	180	4,113
1970.....	4,419	3,092	162	18	260	5,520
1971.....	4,693	3,298	169	17	334	7,063
1972.....	4,913	3,462	174	21	412	8,731
1973.....	5,136	3,607	181	22	500	10,557
1974.....	5,369	3,731	187	23	596	12,581

¹ A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

² An interest rate of 4.75 percent is used in determining the level-costs under the intermediate-cost long-range estimates but in developing the progress of the trust fund a varying rate in the early years has been used.

³ Estimated data for present law.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service.

(g) Long-range operations of OASI trust fund

Table V gives the estimated operations of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty.

In every year after 1969 for the next 15 years, contribution income under the system as it would be modified by your committee's bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the intermediate long-range cost estimate (with a level-earnings assumption), reaching \$89 billion in 1980 and about \$160 billion at the end of this century.

TABLE V.—ESTIMATED PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL, LONG-RANGE-INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments ¹	Administrative expenses	Interest on fund	Balance in fund at end of year
1980.....	\$42,080	\$38,956	\$614	\$3,801	\$89,343
1990.....	47,578	50,140	714	5,868	132,750
2000.....	55,344	56,998	791	7,267	164,715
2025.....	72,031	92,408	1,163	10,621	232,689

¹ Includes effect of financial interchange provision with railroad retirement system.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the special benefits payable to certain noninsured persons aged 72 or over or for the additional benefits payable on the basis of noncontributory credit for military service after 1967—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

(h) Long-range operations of DI trust fund

The disability insurance trust fund, under the program as it would be changed by your committee's bill, grows slowly but steadily after 1969, according to the intermediate long-range cost estimate, as shown by table VI. In 1980, it is shown as being \$18 billion, while in 1990, the corresponding figure is \$29 billion. There is a small excess of contribution income over benefit disbursements for every year after 1969 for the next 20 years.

TABLE VI.—ESTIMATED PROGRESS OF DISABILITY INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL, LONG-RANGE-INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments ¹	Administrative expenses	Interest on fund	Balance in fund at end of year
1980.....	\$5,222	\$4,685	\$176	\$768	\$17,606
1990.....	5,917	5,806	194	1,284	28,855
2000.....	6,887	7,367	238	1,847	41,117
2025.....	8,946	10,697	342	1,980	43,685

¹ Includes effect of financial interchange provision with railroad retirement system.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the additional benefits payable on the basis of noncontributory credit for military service after 1967—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

V. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman) :

SOCIAL SECURITY ACT

* * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Federal Old-Age and Survivors Insurance Trust Fund and Federal

Disability Insurance Trust Fund

Section 201. (a) * * *

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) (A) $\frac{1}{2}$ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1956, and before January 1, 1966, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, **[and]** (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, **[1967, and so reported,]** *1967, and before January 1, 1970, and so reported, and (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and so reported,* which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

(2) (A) $\frac{3}{8}$ of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) and 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, **[and]** (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, *and before January 1, 1970, and (D) 0.825 of 1 per centum of the*

amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

* * * * *

Old-Age and Survivors Insurance Benefit Payments

Old-Age Insurance Benefits

Sec. 202. (a) * * *

Wife's Insurance Benefits

(b) (1) * * *

[(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to whichever of the following is the smaller: (A) one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such months, or (B) \$105.]

(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month.

* * * * *

Husband's Insurance Benefits

(c) (1) * * *

[(3) Except as provided in subsection (q), such husband's insurance benefit for each month shall be equal to whichever of the following is the smaller: (A) one-half of the primary insurance amount of his wife for such month, or (B) \$105.]

(3) Except as provided in subsection (q), such husband's insurance benefit for each month shall be equal to one-half of the primary insurance amount of his wife for such month.

* * * * *

Widow's Insurance Benefits

(e) (1) * * *

(4) If a widow, after attaining the age of 60, marries an individual (other than one described in subparagraph (A) or (B) of paragraph (3)), such marriage shall, for purposes of paragraph (1), be deemed not to have occurred; except that, notwithstanding the provisions of paragraph (2) and subsection (q), such widow's insurance benefit for the month in which such marriage occurs and each month thereafter prior to the month in which the husband dies or such marriage is otherwise terminated, shall be equal to [whichever of the following is the smaller: (A) one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based, or (B) \$105] *one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based;*

* * * * *

Widower's Insurance Benefits

(f) (1) * * *

(5) If a widower, after attaining the age of 62, marries an individual (other than one described in subparagraph (A) or (B) of paragraph (4)), such marriage shall, for purposes of paragraph (1), be deemed not to have occurred; except that, notwithstanding the provisions of paragraph (3) and subsection (q), such widower's insurance benefit for the month in which such marriage occurs and each month thereafter prior to the month in which the wife dies or such marriage is otherwise terminated, shall be equal to [whichever of the following is the smaller: (A) one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based, or (B) \$105] *one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based.*

* * * * *

Reduction of Insurance Benefits

Maximum Benefits

Sec. 203. (a) Whenever the total of monthly benefits to which individuals are entitled under sections 202 and 223 for a month on the basis of the wages and self-employment income of an insured individual is greater than the amount appearing in column V of the table in section 215(a) on the line on which appears in column IV such insured individual's primary insurance amount, such total of benefits shall be reduced to such amount; except that—

(1) when any of such individuals so entitled would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance benefits on the basis of the wages and self-employment income of one or more other insured individuals, such total of benefits shall not be reduced to less than the smaller of: (A) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or (B) the last figure in column V of the table appearing in section 215(a), or

(2) when two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for [the month of February 1968] *January 1970* on the basis of the wages and self-employment income of such insured individual *and at least one such person was so entitled for December 1969 on the basis of such wages and self-employment income*, such total of benefits for [such month] *January 1970* or any subsequent month shall not be reduced to less than the larger of—

(A) the amount determined under this subsection without regard to this paragraph, or

(B) an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), as in effect prior to [February 1968] *January 1970*, for each such person for [February 1968] *such month*, by [113] *115* percent and raising each such increased amount, if it is not a multiple of \$0.10, to the next higher multiple of \$0.10;

but in any such case (i) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subpara-

graph (B), and (ii) if section 202(k)(2)(A) was applicable in the case of any such benefits for [the month of February 1968] *January 1970*, and ceases to apply after such month, the provisions of subparagraph (B) shall be applied, for and after the month in which section 202(k)(2)(A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for [February 1968] *January 1970*, or

* * * * *

Computation of Primary Insurance Amount

Sec. 215. For the purposes of this title—

(a) Subject to the conditions specified in subsections (b), (c), and (d) of this section, the primary insurance amount of an insured individual shall be whichever of the following is the largest:

(1) The amount in column IV on the line on which in column III of the following table appears his average monthly wage (as determined under subsection (b));

(2) The amount in column IV on the line on which in column II of the following table appears his primary insurance amount (as determined under subsection (c));

(3) The amount in column IV on the line on which in column I of the following table appears his primary insurance benefit (as determined under subsection (d)); or

(4) In the case of an individual who was entitled to a disability insurance benefit for the month before the month in which he died, became entitled to old-age insurance benefits, or attained age 65, the amount in column IV which is equal to the primary insurance amount upon which such disability insurance benefit is based.

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND
MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 act, as modified)		II (Primary insurance amount under 1965 act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
-----	\$15.60	\$48.00 or less	-----	\$74	\$55.00	\$82.50
\$15.61-----	16.20	49.00	\$75	76	55.40	83.10
\$16.21-----	16.84	50.00	77	78	56.50	84.80
\$16.85-----	17.60	51.00	79	80	57.70	86.60
\$17.61-----	18.40	52.00	81	81	58.80	88.20
\$18.41-----	19.24	53.00	82	83	59.90	89.90
\$19.25-----	20.00	54.00	84	85	61.10	91.70
\$20.01-----	20.64	55.00	86	87	62.20	93.30
\$20.65-----	21.28	56.00	88	89	63.30	95.00
\$21.29-----	21.88	57.00	90	90	64.50	96.80
\$21.89-----	22.28	58.00	91	92	65.60	98.40

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND
MAXIMUM FAMILY BENEFITS—Continued

I		II	III		IV	V
(Primary insurance benefit under 1939 act, as modified)		(Primary insurance amount under 1965 act)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
\$22.29	\$22.68	\$59.00	\$93	\$94	\$66.70	\$100.10
\$22.69	23.08	60.00	95	96	67.80	101.70
\$23.09	23.44	61.00	97	97	69.00	103.50
\$23.45	23.76	62.10	98	99	70.20	105.30
\$23.77	24.20	63.20	100	101	71.50	107.30
\$24.21	24.60	64.20	102	102	72.60	108.90
\$24.61	25.00	65.30	103	104	73.80	110.70
\$25.01	25.48	66.40	105	106	75.10	112.70
\$25.49	25.92	67.50	107	107	76.30	114.50
\$25.93	26.40	68.50	108	109	77.50	116.30
\$26.41	26.94	69.60	110	113	78.70	118.10
\$26.95	27.46	70.70	114	118	79.90	119.90
\$27.47	28.00	71.70	119	122	81.10	121.70
\$28.01	28.68	72.80	123	127	82.30	123.50
\$28.69	29.25	73.90	128	132	83.60	125.40
\$29.26	29.68	74.90	133	136	84.70	127.10
\$29.69	30.36	76.00	137	141	85.90	128.90
\$30.37	30.92	77.10	142	146	87.20	130.80
\$30.93	31.36	78.20	147	150	88.40	132.60
\$31.37	32.00	79.20	151	155	89.50	134.30
\$32.01	32.60	80.30	156	160	90.80	136.20
\$32.61	33.20	81.40	161	164	92.00	138.00
\$33.21	33.88	82.40	165	169	93.20	139.80
\$33.89	34.50	83.50	170	174	94.40	141.60
\$34.51	35.00	84.60	175	178	95.60	143.40
\$35.01	35.80	85.60	179	183	96.80	146.40
\$35.81	36.40	86.70	184	188	98.00	150.40
\$36.41	37.06	87.80	189	193	99.30	154.40
\$37.09	37.60	88.90	194	197	100.50	157.60
\$37.61	38.20	89.90	198	202	101.60	161.60
\$38.21	39.12	91.00	203	207	102.90	165.60
\$39.13	39.68	92.10	208	211	104.10	168.80
\$39.69	40.33	93.10	212	216	105.20	172.80
\$40.34	41.12	94.20	217	221	106.50	176.80
\$41.13	41.76	95.30	222	225	107.70	180.00
\$41.77	42.44	96.30	226	230	108.90	184.00
\$42.45	43.20	97.40	231	235	110.10	188.00
\$43.21	43.76	98.50	236	239	111.40	191.20
\$43.77	44.44	99.60	240	244	112.60	195.20
\$44.45	44.88	100.60	245	249	113.70	199.20
\$44.89	45.60	101.70	250	253	115.00	202.40
		102.80	254	258	116.20	206.40
		103.80	259	263	117.30	210.40
		104.90	264	267	118.60	213.60
		106.00	268	272	119.80	217.60
		107.00	273	277	121.00	221.60
		108.10	278	281	122.20	224.80
		109.20	282	286	123.40	228.80
		110.30	287	291	124.70	232.80
		111.30	292	295	125.80	236.00
		112.40	296	300	127.10	240.00
		113.50	301	305	128.30	244.00
		114.50	306	309	129.40	247.20
		115.60	310	314	130.70	251.20
		116.70	315	319	131.90	255.20
		117.70	320	323	133.00	258.40
		118.80	324	328	134.30	262.40
		119.90	329	333	135.50	266.40
		121.00	334	337	136.80	269.60
		122.00	338	342	137.90	273.60
		123.10	343	347	139.10	277.60
		124.20	348	351	140.40	280.80
		125.20	352	356	141.50	284.80
		126.30	357	361	142.80	288.80
		127.40	362	365	144.00	292.00
		128.40	366	370	145.10	296.00
		129.50	371	375	146.40	300.00

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND
MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 act, as modified)		II (Primary insurance amount under 1965 act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self- employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		\$130.60	\$376	\$379	\$147.60	\$303.20
		131.70	380	384	148.90	307.20
		132.70	385	389	150.00	311.20
		133.00	390	393	151.20	314.40
		134.90	394	398	152.50	318.40
		135.90	399	403	153.60	322.40
		137.00	404	407	154.90	325.60
		138.00	408	412	156.00	329.60
		139.00	413	417	157.10	333.60
		140.00	418	421	158.20	336.80
		141.00	422	426	159.40	340.80
		142.00	427	431	160.50	344.80
		143.00	432	436	161.60	348.80
		144.00	437	440	162.80	350.40
		145.00	441	445	163.90	352.40
		146.00	446	450	165.00	354.40
		147.00	451	454	166.20	356.00
		148.00	455	459	167.30	358.00
		149.00	460	464	168.40	360.00
		150.00	465	468	169.50	361.60
		151.00	469	473	170.70	363.60
		152.00	474	478	171.80	365.60
		153.00	479	482	172.90	367.20
		154.00	483	487	174.10	369.20
		155.00	483	492	175.20	371.20
		156.00	493	496	176.30	372.80
		157.00	497	501	177.50	374.80
		158.00	502	506	178.60	376.80
		159.00	507	510	179.70	378.40
		160.00	511	515	180.80	380.40
		161.00	516	520	182.00	382.40
		162.00	521	524	183.10	384.00
		163.00	525	529	184.20	386.00
		164.00	530	534	185.40	388.00
		165.00	535	538	186.50	389.60
		166.00	539	543	187.60	391.60
		167.00	544	548	188.80	393.60
		168.00	549	553	189.90	395.60
			554	556	191.00	396.80
			557	560	192.00	398.40
			561	563	193.00	399.60
			564	567	194.00	401.20
			568	570	195.00	402.40
			571	574	196.00	404.00
			575	577	197.00	405.20
			578	581	198.00	406.80
			582	584	199.00	408.00
			585	588	200.00	409.60
			589	591	201.00	410.80
			592	595	202.00	412.40
			596	598	203.00	413.60
			599	602	204.00	415.20
			603	605	205.00	416.40
			606	609	206.00	418.00
			610	612	207.00	419.20
			613	616	208.00	420.80
			617	620	209.00	422.40
			621	623	210.00	423.60
			624	627	211.00	425.20
			628	630	212.00	426.40
			631	634	213.00	428.00
			635	637	214.00	429.20
			638	641	215.00	430.80
			642	644	216.00	432.00
			645	648	217.00	433.60
			649	650	218.00	434.40

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 act, as modified)		II (Primary insurance amount under 1967 act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
-----	\$16.20	\$55.40	-----	\$76	\$64.00	\$96.00
		or less				
\$16.21	16.84	56.50	\$77	78	65.00	96.50
\$16.85	17.60	57.70	79	80	66.40	99.60
\$17.61	18.40	58.80	81	81	67.70	101.60
\$18.41	19.24	59.90	82	83	68.90	103.40
\$19.25	20.00	61.10	84	85	70.30	105.50
\$20.01	20.64	62.20	86	87	71.60	107.40
\$20.65	21.28	63.30	88	89	72.80	109.20
\$21.29	21.88	64.50	90	90	74.20	111.30
\$21.89	22.28	65.60	91	92	75.50	113.30
\$22.29	22.68	66.70	93	94	76.80	115.20
\$22.69	23.08	67.80	95	96	78.00	117.00
\$23.09	23.44	69.00	97	97	79.40	119.10
\$23.45	23.76	70.20	98	99	80.80	121.20
\$23.77	24.20	71.60	100	101	82.50	123.50
\$24.21	24.60	72.60	102	102	83.50	125.30
\$24.61	25.00	73.80	103	104	84.90	127.40
\$25.01	25.48	75.10	105	106	86.40	129.60
\$25.49	25.92	76.30	107	107	87.80	131.70
\$25.93	26.40	77.50	108	109	89.20	133.80
\$26.41	26.94	78.70	110	113	90.60	135.90
\$26.95	27.46	79.90	114	113	91.90	137.90
\$27.47	28.00	81.10	119	122	93.30	140.00
\$28.01	28.68	82.30	123	127	94.70	142.10
\$28.69	29.25	83.60	128	132	96.20	144.30
\$29.26	29.68	84.70	133	136	97.50	146.30
\$29.69	30.36	85.90	137	141	98.80	148.20
\$30.37	30.92	87.20	142	146	100.30	150.50
\$30.93	31.36	88.40	147	150	101.70	152.60
\$31.37	32.00	89.60	151	155	103.00	154.50
\$32.01	32.60	90.80	156	160	104.50	156.80
\$32.61	33.20	92.00	161	164	105.80	158.70
\$33.21	33.88	93.20	165	169	107.20	160.80
\$33.89	34.50	94.40	170	174	108.60	162.90
\$34.51	35.00	95.60	175	178	110.00	165.00
\$35.01	35.80	96.80	179	183	111.40	167.10
\$35.81	36.40	98.00	184	188	112.70	169.10
\$36.41	37.08	99.30	189	193	114.20	171.30
\$37.09	37.60	100.60	194	197	115.60	173.40
\$37.61	38.20	101.60	198	202	116.90	175.40
\$38.21	39.12	102.90	203	207	118.40	177.60
\$39.13	39.68	104.10	208	211	119.80	179.70
\$39.69	40.33	105.20	212	216	121.00	181.50
\$40.34	41.12	106.50	217	221	122.50	183.80
\$41.13	41.76	107.70	222	225	123.90	185.90
\$41.77	42.44	108.90	226	230	125.30	188.00
\$42.45	43.20	110.10	231	235	126.70	190.10
\$43.21	43.76	111.40	236	239	128.20	192.30
\$43.77	44.44	112.60	240	244	129.60	195.20
\$44.45	44.88	113.70	245	249	130.80	199.20
\$44.89	45.60	115.00	250	253	132.30	202.40
		116.20	254	258	133.70	206.40
		117.30	259	263	134.90	210.40
		118.60	264	267	136.40	213.60
		119.80	268	272	137.80	217.60
		121.00	273	277	139.20	221.60
		122.20	278	281	140.60	224.80
		123.40	282	286	142.00	228.80
		124.70	287	291	143.50	232.80
		125.80	292	295	144.70	236.00
		127.10	296	300	146.20	240.00
		128.30	301	305	147.60	244.00

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 act, as modified)		II (Primary insurance amount under 1967 act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		\$129.40	\$306	\$309	\$148.90	\$247.20
		130.70	310	314	150.40	251.20
		131.90	315	319	151.70	255.20
		133.00	320	323	153.00	258.40
		134.30	324	328	154.50	262.40
		135.50	329	333	155.90	266.40
		136.80	334	337	157.40	269.60
		137.90	338	342	158.60	273.60
		139.10	343	347	160.00	277.60
		140.40	348	351	161.60	280.80
		141.50	352	356	162.80	284.80
		142.80	357	361	164.30	288.80
		144.00	362	365	165.60	292.00
		145.10	366	370	166.90	296.00
		146.40	371	375	168.40	300.00
		147.60	376	379	169.80	303.20
		148.90	380	384	171.30	307.20
		150.00	385	389	172.50	311.20
		151.20	390	393	173.90	314.40
		152.50	394	398	175.40	318.40
		153.60	399	403	176.70	322.40
		154.90	404	407	178.20	325.60
		156.00	408	412	179.40	329.60
		157.10	413	417	180.70	333.60
		158.20	418	421	182.00	336.80
		159.40	422	426	183.40	340.80
		160.50	427	431	184.60	344.80
		161.60	432	436	185.90	348.80
		162.80	437	440	187.30	350.40
		163.90	441	445	188.50	352.40
		165.00	446	450	189.80	354.40
		166.20	451	454	191.20	356.00
		167.30	455	459	192.40	358.00
		168.40	460	464	193.70	360.00
		169.50	465	468	195.00	361.60
		170.70	469	473	196.40	363.60
		171.80	474	478	197.60	365.60
		172.90	479	482	198.90	367.20
		174.10	483	487	200.30	369.20
		175.20	488	492	201.50	371.20
		176.30	493	496	202.80	372.80
		177.50	497	501	204.20	374.80
		178.60	502	506	205.40	376.80
		179.70	507	510	206.70	378.40
		180.80	511	515	208.00	380.40
		182.00	516	520	209.30	382.40
		183.10	521	524	210.60	384.00
		184.20	525	529	211.90	386.00
		185.40	530	534	213.30	388.00
		186.50	535	538	214.50	389.60
		187.60	539	543	215.80	391.60
		188.80	544	548	217.20	393.60
		189.90	549	553	218.40	395.60
		191.00	554	556	219.70	396.80
		192.00	557	560	220.80	398.40
		193.00	561	563	222.00	399.60
		194.00	564	567	223.10	401.20
		195.00	568	570	224.30	402.40
		196.00	571	574	225.40	404.00
		197.00	575	577	226.60	405.20
		198.00	578	581	227.70	406.80
		199.00	582	584	228.90	408.00
		200.00	585	588	230.00	409.60

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 act, as modified)		II (Primary insurance amount under 1967 act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		\$201.00	\$589	\$591	\$251.20	\$410.80
		202.00	592	595	252.30	412.40
		203.00	596	598	253.60	413.60
		204.00	599	602	254.60	415.20
		205.00	603	605	255.80	416.40
		206.00	606	609	256.90	418.00
		207.00	610	612	258.10	419.20
		208.00	613	616	259.20	420.80
		209.00	617	620	240.40	422.40
		210.00	621	623	241.60	423.60
		211.00	624	627	242.70	425.20
		212.00	628	630	243.80	426.40
		213.00	631	634	245.00	428.00
		214.00	635	637	246.10	429.20
		215.00	638	641	247.30	430.80
		216.00	642	644	248.40	432.00
		217.00	645	648	249.60	433.60
		218.00	649	650	250.70	434.40

Average Monthly Wage

(b) (1) * * *

(4) The provisions of this subsection shall be applicable only in the case of an individual—

(A) who becomes entitled, after [January 1968] December 1969 to benefits under section 202(a) or section 223; or

(B) who dies after [January 1968] December 1969 without being entitled to benefits under section 202(a) or section 223; or

(C) whose primary insurance amount is required to be recomputed under subsection (f) (2).

Primary Insurance Amount Under [1965] 1967 Act

(c) (1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the enactment of the Social Security Amendments of [1967] 1969.

(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202(a) or section 223 before [the month of February 1968] January 1970, or who died before such month.

* * * * *

Transitional Insured Status

Sec. 227. (a) In the case of any individual who attains the age of 72 before 1969 but who does not meet the requirements of section 214(a), the 6 quarters of coverage referred to in so much of paragraph (1) of section 214(a) as follows clause (C) shall, instead, be 3 quarters of coverage for purposes of determining entitlement of such individual to benefits under section 202(a), and of his wife to benefits under section 202(b), but, in the case of such wife, only if she attains the age of 72 before 1969 and only with respect to wife's insurance benefits under section 202(b) for and after the month in which she attains such age. For each month before the month in which any such individual meets the requirements of section 214(a), the amount of his old-age insurance benefit shall, notwithstanding the provisions of section 202(a), be **[\$40]** \$46, and the amount of the wife's insurance benefit of his wife shall, notwithstanding the provisions of section 202(b), be **[\$20]** \$23.

(b) In the case of any individual who has died, who does not meet the requirements of section 214(a), and whose widow attains age 72 before 1969, the 6 quarters of coverage referred to in paragraph (3) of section 214(a) and in so much of paragraph (1) thereof as follows clause (C) shall, for purposes of determining her entitlement to widow's insurance benefits under section 202(e), instead be—

(1) 3 quarters of coverage if such widow attains the age of 72 in or before 1966,

(2) 4 quarters of coverage if such widow attains the age of 72 in 1967, or

(3) 5 quarters of coverage if such widow attains the age of 72 in 1968.

The amount of her widow's insurance benefit for each month shall, notwithstanding the provisions of section 202(e) (and section 202(m)), be **[\$40]** \$46.

* * * * *

Benefits at Age 72 for Certain Uninsured Individuals

Eligibility

Sec. 228. (a) * * *

Benefit Amount

(b) (1) Except as provided in paragraph (2), the benefit amount to which an individual is entitled under this section for any month shall be **[\$40.]** \$46.

(2) If both husband and wife are entitled (or upon application would be entitled) to benefits under this section for any month, the amount of the husband's benefit for such month shall be **[\$40]** \$46 and the amount of the wife's benefit for such month shall be **[\$20.]** \$23.

Reduction for Governmental Pension System Benefits

(c) (1) The benefit amount of any individual under this section for any month shall be reduced (but not below zero) by the amount of any periodic benefit under a governmental pension system for which he is eligible for such month.

(2) In the case of a husband and wife only one of whom is entitled to benefits under this section for any month, the benefit amount, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the spouse who is not entitled to benefits under this section is eligible for such month, over (B) **[\$20]** \$23.

(3) In the case of a husband and wife both of whom are entitled to benefits under this section for any month—

(A) the benefit amount of the wife, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (i) the total amount of any periodic benefits under governmental pension systems for which the husband is eligible for such month, over (ii) **[\$40]** \$46, and

(B) the benefit amount of the husband, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (i) the total amount of any periodic benefits under governmental pension systems for which the wife is eligible for such month, over (ii) **[\$20]** \$23.

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SEPARATE VIEWS OF JACOB H. GILBERT

The 15-percent increase in social security benefits, effective January 1, 1970, recommended by the House Ways and Means Committee, will compensate social security beneficiaries for the rapidly rising living costs that have seriously eroded their benefits. Simple justice requires that our social security beneficiaries receive an immediate increase in benefits in order to maintain the buying power of their benefits in these times of rapid inflation.

Separating an immediate increase from other social security legislation will permit the fastest possible relief to social security beneficiaries beset by rapidly rising living costs. This approach also will allow the committee the time necessary to give major social security reform the comprehensive review such complex proposals require without penalizing social security beneficiaries by delay. The benefit increase should be looked on as stopgap legislation to allow time for development of a fuller program.

My bill, H.R. 14430, which is pending before the committee, would provide additional benefit increases, a two-step increase in the minimum benefit to \$120 a month by January 1, 1972, and would abolish the premium for medicare part B—now \$4 monthly—and make other much needed improvements in the social security and medicare programs. I am sure that in the coming months the committee will consider the proposals under my bill, H.R. 14430, and other pending social security legislation.

JACOB H. GILBERT.

(21)



Public Law 91-172 (H. R. 13270),
December 30, 1969, Title X --
Increase in Social Security
Benefits

vs pending in the Tax Court of the United States before the date enactment of this Act shall result from the enactment of this Act.

SEC. 962. EFFECTIVE DATES.

(a) The amendments made by sections 951, 953, 954 (c) and (e), 955, 956, 958, and 960 (c), (d), (e), (g), and (j) shall take effect on the date of enactment of this Act.

Ante, pp. 730,
732, 734.

(b) The amendment made by section 952(a) shall apply to judges appointed after the date of enactment of this Act.

(c) The amendment made by section 952(b) shall take effect on the date of enactment of this Act, except that—

(1) the term of office being served by a judge of the Tax Court on that date shall expire on the date it would have expired under the law in effect on the date preceding the date of enactment of this Act; and

(2) a judge of the Tax Court on the date of enactment of this Act may be reappointed in the same manner as a judge of the Tax Court hereafter appointed.

(d) The amendments made by subsections (a), (b), and (d) of section 954 shall apply to—

(1) all judges of the Tax Court retiring on or after the date of enactment of this Act, and

(2) all individuals performing judicial duties pursuant to section 7447(c) or receiving retired pay pursuant to section 7447(d) on the day preceding the date of enactment of this Act.

26 USC 7447.
Ante, p. 730.

Any individual who has served as a judge of the Tax Court for 18 years or more by the end of one year after the date of the enactment of this Act may retire in accordance with the provisions of section 7447 of the Internal Revenue Code of 1954 as in effect on the day preceding the date of the enactment of this Act. Any individual who is a judge of the Tax Court on the date of the enactment of this Act may retire under the provisions of section 7447 of such Code upon the completion of the term of his office, if he is not reappointed as a judge of the Tax Court and gives notice to the President within the time prescribed by section 7447(b) of such Code (or if his term expires within 6 months after the date of enactment of this Act, gives notice to the President before the expiration of 3 months after the date of enactment of this Act), and shall receive retired pay at a rate which bears the same ratio to the rate of the salary payable to a judge as the number of years he has served as a judge of the Tax Court bears to 15; except that the rate of such retired pay shall not exceed the rate of the salary of a judge of the Tax Court. For purposes of the preceding sentence the years of service as a judge of the Tax Court shall be determined in the manner set forth in section 7447(d) of such Code.

Ante, p. 730.

(e) The amendments made by sections 957 and 960 (a), (b), (f), and (i) shall take effect one year after the date of enactment of this Act.

Ante, p. 733.

(f) The amendments made by sections 959 and 960(h) shall take effect 30 days after the date of the enactment of this Act. In the case of any decision of the Tax Court entered before the 30th day after the date of the enactment of this Act, the United States Courts of Appeals shall have jurisdiction to hear an appeal from such decision, if such appeal was filed within the time prescribed by Rule 13(a) of the Federal Rules of Appellate Procedure or by section 7483 of the Internal Revenue Code of 1954, as in effect at the time the decision of the Tax Court was entered.

28 USC app.
Ante, p. 734.

TITLE X—INCREASE IN SOCIAL SECURITY BENEFITS

SEC. 1001. SHORT TITLE.

Social Security
Amendments of
1969.

This title may be cited as the "Social Security Amendments of 1969".

SEC. 1002. INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS.

42 USC 415.

(a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1967 Act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self- employment income shall be—
At least—	But not more than—		At least—	But not more than—		
	\$16.20	\$55.40 or less		\$76	\$64.00	\$96.00
\$16.21	16.84	56.50	\$77	78	65.00	97.50
16.85	17.60	57.70	79	80	66.40	99.60
17.61	18.40	58.80	81	82	67.70	101.60
18.41	19.24	59.90	83	84	68.90	103.40
19.25	20.00	61.10	85	86	70.30	105.50
20.01	20.64	62.20	87	88	71.60	107.40
20.65	21.28	63.30	89	90	72.80	109.20
21.29	21.88	64.50	91	92	74.20	111.30
21.89	22.28	65.60	93	94	75.50	113.30
22.29	22.68	66.70	95	96	76.80	115.20
22.69	23.08	67.80	97	98	78.00	117.00
23.09	23.44	69.00	99	100	79.40	119.10
23.45	23.76	70.20	101	102	80.80	121.20
23.77	24.20	71.50	103	104	82.30	123.50
24.21	24.60	72.60	105	106	83.50	125.30
24.61	25.00	73.80	107	108	84.90	127.40
25.01	25.48	75.10	109	110	86.40	129.60
25.49	25.92	76.30	111	112	87.80	131.70
25.93	26.40	77.50	113	114	89.20	133.80
26.41	26.94	78.70	115	116	90.60	135.90
26.95	27.46	79.90	117	118	91.90	137.90
27.47	28.00	81.10	119	120	93.30	140.00
28.01	28.68	82.30	121	122	94.70	142.10
28.69	29.25	83.60	123	124	96.20	144.30
29.26	29.68	84.70	125	126	97.50	146.30
29.69	30.36	85.90	127	128	98.80	148.20
30.37	30.92	87.20	129	130	100.30	150.50
30.93	31.36	88.40	131	132	101.70	152.60
31.37	32.00	89.50	133	134	103.00	154.50
32.01	32.60	90.80	135	136	104.50	156.80
32.61	33.20	92.00	137	138	105.80	158.70
33.21	33.88	93.20	139	140	107.20	160.80
33.89	34.50	94.40	141	142	108.60	162.90
34.51	35.00	95.60	143	144	110.00	165.00
35.01	35.80	96.80	145	146	111.40	167.10
35.81	36.40	98.00	147	148	112.70	169.10
36.41	37.08	99.30	149	150	114.20	171.30
37.09	37.60	100.50	151	152	115.60	173.40
37.61	38.20	101.60	153	154	116.90	175.40
38.21	39.12	102.90	155	156	118.40	177.60
39.13	39.68	104.10	157	158	119.80	179.70
39.69	40.33	105.20	159	160	121.00	181.50
40.34	41.12	106.50	161	162	122.50	183.80
41.13	41.76	107.70	163	164	123.90	185.90
41.77	42.44	108.90	165	166	125.30	188.00
42.45	43.20	110.10	167	168	126.70	190.10
43.21	43.76	111.40	169	170	128.20	192.30
43.77	44.44	112.60	171	172	129.50	195.20
44.45	44.88	113.70	173	174	130.80	199.20
44.89	45.60	115.00	175	176	132.30	202.40
		116.20	177	178	133.70	206.40
		117.30	179	180	134.90	210.40

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1967 Act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self- employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		\$118. 60	\$264	\$267	\$136. 40	\$213. 60
		119. 80	268	272	137. 80	217. 60
		121. 00	273	277	139. 20	221. 60
		122. 20	278	281	140. 60	224. 80
		123. 40	282	286	142. 00	228. 80
		124. 70	287	291	143. 50	232. 80
		125. 80	292	295	144. 70	236. 00
		127. 10	296	300	146. 20	240. 00
		128. 30	301	305	147. 60	244. 00
		129. 40	306	309	148. 90	247. 20
		130. 70	310	314	150. 40	251. 20
		131. 90	315	319	151. 70	255. 20
		133. 00	320	323	153. 00	258. 40
		134. 30	324	328	154. 50	262. 40
		135. 50	329	333	155. 90	266. 40
		136. 80	334	337	157. 40	269. 60
		137. 90	338	342	158. 60	273. 60
		139. 10	343	347	160. 00	277. 60
		140. 40	348	351	161. 50	280. 80
		141. 50	352	356	162. 80	284. 80
		142. 80	357	361	164. 30	288. 80
		144. 00	362	365	165. 60	292. 00
		145. 10	366	370	166. 90	296. 00
		146. 40	371	375	168. 40	300. 00
		147. 60	376	379	169. 80	303. 20
		148. 90	380	384	171. 30	307. 20
		150. 00	385	389	172. 50	311. 20
		151. 20	390	393	173. 90	314. 40
		152. 50	394	398	175. 40	318. 40
		153. 60	399	403	176. 70	322. 40
		154. 90	404	407	178. 20	325. 60
		156. 00	408	412	179. 40	329. 60
		157. 10	413	417	180. 70	333. 60
		158. 20	418	421	182. 00	336. 80
		159. 40	422	426	183. 40	340. 80
		160. 50	427	431	184. 60	344. 80
		161. 60	432	436	185. 90	348. 80
		162. 80	437	440	187. 30	350. 40
		163. 90	441	445	188. 50	352. 40
		165. 00	446	450	189. 80	354. 40
		166. 20	451	454	191. 20	356. 00
		167. 30	455	459	192. 40	358. 00
		168. 40	460	464	193. 70	360. 00
		169. 50	465	468	195. 00	361. 60
		170. 70	469	473	196. 40	363. 60
		171. 80	474	478	197. 60	365. 60
		172. 90	479	482	198. 90	367. 20
		174. 10	483	487	200. 30	369. 20
		175. 20	488	492	201. 50	371. 20
		176. 30	493	496	202. 80	372. 80
		177. 50	497	501	204. 20	374. 80
		178. 60	502	506	205. 40	376. 80
		179. 70	507	510	206. 70	378. 40
		180. 80	511	515	208. 00	380. 40
		182. 00	516	520	209. 30	382. 40
		183. 10	521	524	210. 60	384. 00
		184. 20	525	529	211. 90	386. 00
		185. 40	530	534	213. 30	388. 00
		186. 50	535	538	214. 50	389. 60
		187. 60	539	543	215. 80	391. 60
		188. 80	544	548	217. 20	393. 60
		189. 90	549	553	218. 40	395. 60
		191. 00	554	556	219. 70	396. 80
		192. 00	557	560	220. 80	398. 40
		193. 00	561	563	222. 00	399. 60
		194. 00	564	567	223. 10	401. 20
		195. 00	568	570	224. 30	402. 40
		196. 00	571	574	225. 40	404. 00
		197. 00	575	577	226. 60	405. 20
		198. 00	578	581	227. 70	406. 80
		199. 00	582	584	228. 90	408. 00
		200. 00	585	588	230. 00	409. 60

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1967 Act)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self- employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		\$201.00	\$589	\$591	\$231.20	\$410.80
		202.00	592	595	232.30	412.40
		203.00	596	598	233.50	413.60
		204.00	599	602	234.60	415.20
		205.00	603	605	235.80	416.40
		206.00	606	609	236.90	418.00
		207.00	610	612	238.10	419.20
		208.00	613	616	239.20	420.80
		209.00	617	620	240.40	422.40
		210.00	621	623	241.50	423.60
		211.00	624	627	242.70	425.20
		212.00	628	630	243.80	426.40
		213.00	631	634	245.00	428.00
		214.00	635	637	246.10	429.20
		215.00	638	641	247.30	430.80
		216.00	642	644	248.40	432.00
		217.00	645	648	249.60	433.60
		218.00	649	650	250.70	434.40".

42 USC 403.

(b) (1) Section 203(a) of such Act is amended by striking out paragraph (2) and inserting in lieu thereof the following:

42 USC 402,
423.

"(2) when two or more persons were entitled (without the application of section 202(j) (1) and section 223(b)) to monthly benefits under section 202 or 223 for January 1970 on the basis of the wages and self-employment income of such insured individual and at least one such person was so entitled for December 1969 on the basis of such wages and self-employment income, such total of benefits for January 1970 or any subsequent month shall not be reduced to less than the larger of—

42 USC 422.

"(A) the amount determined under this subsection without regard to this paragraph, or

"(B) an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of the Social Security Amendments of 1969 (and prior to January 1, 1970), for each such person for such month, by 115 percent and raising each such increased amount, if it is not a multiple of \$0.10, to the next higher multiple of \$0.10;

but in any such case (i) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B), and (ii) if section 202(k) (2) (A) was applicable in the case of any such benefits for January 1970, and ceases to apply after such month, the provisions of subparagraph (B) shall be applied, for and after the month in which section 202(k) (2) (A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for January 1970, or".

(2) Notwithstanding any other provision of law, when two or more persons are entitled to monthly insurance benefits under title II of the Social Security Act for any month after 1969 on the basis of the wages and self-employment income of an insured individual (and at least one of such persons was so entitled for a month before January 1971 on the basis of an application filed before 1971), the total of the benefits to which such persons are entitled under such title for such month (after the application of sections 203(a) and 202(q) of such Act) shall be not less than the total of the monthly insurance benefits to which such persons would be entitled under such title for such month (after the application of such sections 203(a) and 202(q)) without regard to the amendment made by subsection (a) of this section. 42 USC 401-429.
Ante, p. 739.
42 USC 402.

(c) Section 215(b)(4) of such Act is amended by striking out "January 1968" each time it appears and inserting in lieu thereof "December 1969". 42 USC 415.

(d) Section 215(c) of such Act is amended to read as follows:

"Primary Insurance Amount Under 1967 Act

"(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed on the basis of the law in effect prior to the enactment of the Social Security Amendments of 1969. Ante, p. 737.

"(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202(a) or section 223 before January 1970, or who died before such month." 42 USC 423.

(e) The amendments made by this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1969 and with respect to lump-sum death payments under such title in the case of deaths occurring after December 1969.

(f) If an individual was entitled to a disability insurance benefit under section 223 of the Social Security Act for December 1969 and became entitled to old-age insurance benefits under section 202(a) of such Act for January 1970, or he died in such month, then, for purposes of section 215(a)(4) of the Social Security Act (if applicable), the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215(c) of such Act) instead of the amount in column IV equal to the primary insurance amount on which his disability insurance benefit is based.

SEC. 1003. INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER.

(a)(1) Section 227(a) of the Social Security Act is amended by striking out "\$40" and inserting in lieu thereof "\$46", and by striking out "\$20" and inserting in lieu thereof "\$23". 42 USC 427.

(2) Section 227(b) of such Act is amended by striking out "\$40" and inserting in lieu thereof "\$46".

(b)(1) Section 228(b)(1) of such Act is amended by striking out "\$40" and inserting in lieu thereof "\$46". 42 USC 428.

(2) Section 228(b)(2) of such Act is amended by striking out "\$40" and inserting in lieu thereof "\$46", and by striking out "\$20" and inserting in lieu thereof "\$23".

(3) Section 228(c)(2) of such Act is amended by striking out "\$20" and inserting in lieu thereof "\$23".

42 USC 428.

(4) Section 228(c)(3)(A) of such Act is amended by striking out "\$40" and inserting in lieu thereof "\$46".

(5) Section 228(c)(3)(B) of such Act is amended by striking out "\$20" and inserting in lieu thereof "\$23".

42 USC 401-429.

(c) The amendments made by subsections (a) and (b) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1969.

SEC. 1004. MAXIMUM AMOUNT OF A WIFE'S OR HUSBAND'S INSURANCE BENEFIT.

42 USC 402.

(a) Section 202(b)(2) of the Social Security Act is amended to read as follows:

"(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month."

(b) Section 202(c)(3) of such Act is amended to read as follows:

"(3) Except as provided in subsection (q), such husband's insurance benefit for each month shall be equal to one-half of the primary insurance amount of his wife for such month."

(c) Sections 202(e)(4) and 202(f)(5) of such Act are each amended by striking out "whichever of the following is the smaller: (A) one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based, or (B) \$105" and inserting in lieu thereof "one-half of the primary insurance amount of the deceased individual on whose wages and self-employment income such benefit is based".

(d) The amendments made by subsections (a), (b), and (c) shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1969.

SEC. 1005. ALLOCATION TO DISABILITY INSURANCE TRUST FUND.

42 USC 401.

(a) Section 201(b)(1) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (B); and

(2) by striking out "1967, and so reported," and inserting in lieu thereof the following: "1967, and before January 1, 1970, and so reported, and (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and so reported,".

(b) Section 201(b)(2) of such Act is amended—

(1) by striking out "and" at the end of clause (B); and

(2) by striking out "1967," and inserting in lieu thereof the following: "1967, and before January 1, 1970, and (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969,".

SEC. 1006. DISREGARDING OF RETROACTIVE PAYMENT OF OASDI BENEFIT INCREASE.

42 USC 302, 602,
1202, 1352,
1382.

Notwithstanding the provisions of sections 2(a)(10), 402(a)(7), 1002(a)(8), 1402(a)(8), and 1602(a)(13) and (14) of the Social Security Act, each State, in determining need for aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV, of such Act, shall disregard (and the plan shall be deemed to require the State to disregard), in addition to any other amounts which the State is required or permitted to disregard in determining such need, any amount paid to an individual under title II of such Act (or under the Railroad Retirement Act of 1937 by reason of the first proviso in section 3(e) thereof), in any month after December 1969, to the extent that (1) such payment is attributable to the increase in monthly benefits under the old-age, survivors, and

45 USC 228c.

disability insurance system for January or February 1970 resulting from the enactment of this title, and (2) the amount of such increase is paid separately from the rest of the monthly benefit of such individual for January or February 1970.

SEC. 1007. DISREGARDING OF INCOME OF OASDI RECIPIENTS IN DETERMINING NEED FOR PUBLIC ASSISTANCE.

In addition to the requirements imposed by law as a condition of approval of a State plan to provide aid or assistance in the form of money payments to individuals under title I, X, XIV, or XVI of the Social Security Act, there is hereby imposed the requirement (and the plan shall be deemed to require) that, in the case of any individual receiving aid or assistance for any month after March 1970 and before July 1970 who also receives in such month a monthly insurance benefit under title II of such Act which is increased as a result of the enactment of the other provisions of this title, the sum of the aid or assistance received by him for such month, plus the monthly insurance benefit received by him in such month (not including any part of such benefit which is disregarded under section 1006), shall exceed the sum of the aid or assistance which would have been received by him for such month under such plan as in effect for March 1970, plus the monthly insurance benefit which would have been received by him in such month without regard to the other provisions of this title, by an amount equal to \$4 or (if less) to such increase in his monthly insurance benefit under such title II (whether such excess is brought about by disregarding a portion of such monthly insurance benefit or otherwise).

42 USC 301, 1201,
1351, 1381.

42 USC 401-429.

42 USC 1206.

Approved December 30, 1969, 9:30 a.m.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 91-413 (Part 1), No. 91-413 (Part 2) (Comm. on Ways & Means) and No. 91-782 (Comm. of Conference).

SENATE REPORT No. 91-552 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 115 (1969):

Aug. 6, 7, Dec. 11: Considered and passed House.

Nov. 21, 24-26, Dec. 1-6, 8-11: Considered and passed Senate, amended.

Dec. 22: House and Senate agreed to conference report.



Conference Report (To accompany
H. R. 13,270), House of Repre-
sentatives Report No. 91-782,
Excerpts from

TITLE X—INCREASE IN SOCIAL SECURITY BENEFITS

The Senate amendment added to the House bill a new title X (the "Social Security Amendments of 1969") increasing social security benefits and making related changes in the OASDI and public assistance programs.

1. Benefit increase and related OASDI provisions

The Senate amendment increased regular OASDI benefits by 15 percent with a minimum primary insurance amount of \$100, beginning January 1970, and provided a similar (15 percent) increase in the special payments for certain individuals aged 72 and older who have no coverage or whose coverage is insufficient to qualify for regular benefits. In addition, it eliminated the \$105 limitation on wife's, husband's, widow's, and widower's insurance benefits, revised the allocation of tax receipts between the OASI and DI trust funds, and raised from \$7,800 to \$12,000 (beginning January 1973) the social security earnings base for benefit and tax purposes.

Although the House bill itself had no corresponding provisions, H.R. 15095 (which passed the House on December 15, 1969) contained provisions which are the same as those in the Senate amendment except that (a) the minimum primary insurance amount is left at \$64 (the figure which results from simply applying the 15-percent increase to the existing \$55 minimum), and (b) the earnings base is not raised above its present level of \$7,800.

The conference substitute (secs. 1002 through 1005) follows H.R. 15095; i.e., it retains, with technical modifications, those benefit increase provisions of the Senate amendment which are also contained in H.R. 15095 and omits those provisions (the specially increased minimum PIA and the higher earnings base) which are not.

2. Public assistance provisions

The Senate amendment also contained provisions designed to assure that at least a part of the OASDI benefit increase will be reflected in the total income of public assistance recipients; under these provisions each State is required, in determining need under any of the public assistance programs, to disregard any retroactive social security benefit increase payments (including those made under future laws as well as those resulting from this increase), and in addition to disregard \$7.50 per month of the income of each adult public assistance recipient or (if the State is already satisfying this requirement) to otherwise provide at least a \$7.50 increase in the amount of such recipient's aid or assistance.

The conference substitute contains provisions which are similar in intent to those in the Senate amendment.

Under section 1006 of the conference substitute, each State is required (in determining the need of its public assistance recipients) to disregard any retroactive payment of the OASDI benefit increase provided by the bill for January and February 1970, which is expected to be paid (by separate check) in April; but this requirement would be limited to the situation created by the bill and would not apply to any retroactive payments which may result from future laws.

Under section 1007 of the conference substitute, each State is also required (in determining the need of its public assistance recipients)

to assure that every recipient of aid or assistance under any of its adult public assistance programs who also receives an OASDI benefit which is increased under the bill will realize an increase in the total of his public assistance and OASDI benefit payments equal to \$4 a month (or the amount of the increase in his OASDI benefit if less), whether such increase in his total payments is brought about by disregarding a portion of his OASDI benefit or otherwise (e.g., by raising the State's standard of assistance for all recipients under the program involved). This requirement is made applicable only to months before July 1970 in order to allow the Congress time to consider the matter in connection with its work on major welfare proposals early next year.

The 15-percent OASDI benefit increase will mean an average \$9.50 increase to those beneficiaries also eligible for public assistance under the programs of aid or assistance to the aged, blind, and disabled. This increase is more than sufficient to meet the requirement (discussed above) that all such persons have their total incomes raised by \$4 a month. Moreover, for practically all States, the savings from the remaining \$5.50 will be sufficient to raise the incomes of those not receiving OASDI benefits by \$4 a month; and the conferees hope that the States will do so.

Senate provision omitted—social security retirement age

The Senate amendment contained a provision making qualified individuals eligible for actuarially reduced OASDI benefits at age 60, instead of at age 62 as under present law, to be effective upon a determination by the President that it is desirable to expand consumer purchasing power by making additional persons eligible for such benefits. The conference substitute omits this provision.

Public Law 91-173 (S. 2917),
December 30, 1969, Federal
Coal Mine Health and Safety
Act of 1969



Public Law 91-173
91st Congress, S. 2917
December 30, 1969

An Act

To provide for the protection of the health and safety of persons working in the coal mining industry of the United States, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Coal Mine Health and Safety Act of 1969".

Federal Coal
Mine Health and
Safety Act of
1969.

FINDINGS AND PURPOSE

SEC. 2. Congress declares that—

(a) the first priority and concern of all in the coal mining industry must be the health and safety of its most precious resource—the miner; 83 STAT. 742, 83 STAT. 743

(b) deaths and serious injuries from unsafe and unhealthful conditions and practices in the coal mines cause grief and suffering to the miners and to their families;

(c) there is an urgent need to provide more effective means and measures for improving the working conditions and practices in the Nation's coal mines in order to prevent death and serious physical harm, and in order to prevent occupational diseases originating in such mines;

(d) the existence of unsafe and unhealthful conditions and practices in the Nation's coal mines is a serious impediment to the future growth of the coal mining industry and cannot be tolerated;

(e) the operators of such mines with the assistance of the miners have the primary responsibility to prevent the existence of such conditions and practices in such mines;

(f) the disruption of production and the loss of income to operators and miners as a result of coal mine accidents or occupationally caused diseases unduly impedes and burdens commerce; and

(g) it is the purpose of this Act (1) to establish interim mandatory health and safety standards and to direct the Secretary of Health, Education, and Welfare and the Secretary of the Interior to develop and promulgate improved mandatory health or safety standards to protect the health and safety of the Nation's coal miners; (2) to require that each operator of a coal mine and every miner in such mine comply with such standards; (3) to cooperate with, and provide assistance to, the States in the development and enforcement of effective State coal mine health and safety programs; and (4) to improve and expand, in cooperation with the States and the coal mining industry, research and development and training programs aimed at preventing coal mine accidents and occupationally caused diseases in the industry.

DEFINITIONS

SEC. 3. For the purpose of this Act, the term—

(a) "Secretary" means the Secretary of the Interior or his delegate;

(b) "commerce" means trade, traffic, commerce, transportation, or communication among the several States, or between a place in a State and any place outside thereof, or within the District of Columbia or a possession of the United States, or between points in the same State but through a point outside thereof;

(c) "State" includes a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands;

(d) "operator" means any owner, lessee, or other person who operates, controls, or supervises a coal mine;

(e) "agent" means any person charged with responsibility for the operation of all or a part of a coal mine or the supervision of the miners in a coal mine;

(f) "person" means any individual, partnership, association, corporation, firm, subsidiary of a corporation, or other organization;

(g) "miner" means any individual working in a coal mine;

(h) "coal mine" means an area of land and all structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations, and other property, real or personal, placed upon, under, or above the surface of such land by any person, used in, or to be used in, or resulting from, the work of extracting in such area bituminous coal, lignite, or anthracite from its natural deposits in the earth by any means or method, and the work of preparing the coal so extracted, and includes custom coal preparation facilities;

(i) "work of preparing the coal" means the breaking, crushing, sizing, cleaning, washing, drying, mixing, storing, and loading of bituminous coal, lignite, or anthracite, and such other work of preparing such coal as is usually done by the operator of the coal mine;

(j) "imminent danger" means the existence of any condition or practice in a coal mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated;

(k) "accident" includes a mine explosion, mine ignition, mine fire, or mine inundation, or injury to, or death of, any person;

(l) "mandatory health or safety standard" means the interim mandatory health or safety standards established by titles II and III of this Act, and the standards promulgated pursuant to title I of this Act; and

(m) "Panel" means the Interim Compliance Panel established by this Act.

MINES SUBJECT TO ACT

SEC. 4. Each coal mine, the products of which enter commerce, or the operations or products of which affect commerce, and each operator of such mine, and every miner in such mine shall be subject to the provisions of this Act.

INTERIM COMPLIANCE PANEL

SEC. 5. (a) There is hereby established the Interim Compliance Panel, which shall be composed of five members as follows:

(1) Assistant Secretary of Labor for Labor Standards, Department of Labor, or his delegate;

(2) Director of the Bureau of Standards, Department of Commerce, or his delegate;

(3) Administrator of Consumer Protection and Environmental Health Service, Department of Health, Education, and Welfare, or his delegate;

(4) Director of the Bureau of Mines, Department of the Interior, or his delegate; and

Establishment;
membership.

(5) Director of the National Science Foundation, or his delegate.

(b) Members of the Panel shall serve without compensation in addition to that received in their regular employment, but shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by them in the performance of duties vested in the Panel.

Travel
expenses, etc.

(c) Notwithstanding any other provision of law, the Secretary of Health, Education, and Welfare, the Secretary of Commerce, the Secretary of Labor, and the Secretary shall, upon request of the Panel, provide the Panel such personnel and other assistance as the Panel determines necessary to enable it to carry out its functions under this Act.

Agency
cooperation.

(d) Three members of the Panel shall constitute a quorum for doing business. All decisions of the Panel shall be by majority vote. The chairman of the Panel shall be selected by the members from among the membership thereof.

Quorum.

(e) The Panel is authorized to appoint as many hearing examiners as are necessary for proceedings required to be conducted in accordance with the provisions of this Act. The provisions applicable to hearing examiners appointed under section 3105 of title 5 of the United States Code shall be applicable to hearing examiners appointed pursuant to this subsection.

Hearing
examiners,
appointment.

80 Stat. 415.

(f) (1) It shall be the function of the Panel to carry out the duties imposed on it pursuant to this Act and to provide an opportunity for a public hearing, after notice, at the request of an operator of the affected coal mine or the representative of the miners of such mine. Any operator or representative of miners aggrieved by a final decision of the Panel may file a petition for review of such decision under section 106 of this Act. The provisions of this section shall terminate upon completion of the Panel's functions as set forth under this Act. Any hearing held pursuant to this subsection shall be of record and the Panel shall make findings of fact and shall issue a written decision incorporating its findings therein in accordance with section 554 of title 5 of the United States Code.

Duties.

Post, p. 754.

(2) The Panel shall make an annual report, in writing, to the Secretary for transmittal by him to the Congress concerning the achievement of its purposes, and any other relevant information (including any recommendations) which it deems appropriate.

80 Stat. 384.
Annual report
to Secretary
and Congress.

TITLE I—GENERAL

HEALTH AND SAFETY STANDARDS; REVIEW

SEC. 101. (a) The Secretary shall, in accordance with the procedures set forth in this section, develop, promulgate, and revise, as may be appropriate, improved mandatory safety standards for the protection of life and the prevention of injuries in a coal mine, and shall, in accordance with the procedures set forth in this section, promulgate the mandatory health standards transmitted to him by the Secretary of Health, Education, and Welfare.

(b) No improved mandatory health or safety standard promulgated under this title shall reduce the protection afforded miners below that provided by any mandatory health or safety standard.

(c) In the development and revision of mandatory safety standards, the Secretary shall consult with the Secretary of Health, Education, and Welfare, the Secretary of Labor, and with other interested Federal

agencies, appropriate representatives of State agencies, appropriate representatives of the coal mine operators and miners, other interested persons and organizations, and such advisory committees as he may appoint. Such development and revision of mandatory safety standards shall be based upon research, demonstrations, experiments, and such other information as may be appropriate. In addition to the attainment of the highest degree of safety protection for miners, other considerations shall be the latest available scientific data in the field, the technical feasibility of the standards, and experience gained under this and other safety statutes.

(d) The Secretary of Health, Education, and Welfare shall, in accordance with the procedures set forth in this section, develop and revise, as may be appropriate, improved mandatory health standards for the protection of life and the prevention of occupational diseases of miners. In the development and revision of mandatory health standards, the Secretary of Health, Education, and Welfare shall consult with the Secretary, the Secretary of Labor, and with other interested Federal agencies, appropriate representatives of State agencies, appropriate representatives of the coal mine operators and miners, other interested persons and organizations, such advisory committees as he may appoint, and, where appropriate, foreign countries. Such development and revision of mandatory standards shall be based upon research, demonstrations, experiments, and such other information as may be appropriate. In addition to the attainment of the highest degree of health protection for the miner, other considerations shall be the latest available scientific data in the field, the technical feasibility of the standards, and experience gained under this and other health statutes. Mandatory health standards which the Secretary of Health, Education, and Welfare develops or revises shall be transmitted to the Secretary, and shall thereupon be published in the Federal Register by the Secretary as proposed mandatory health standards.

(e) The Secretary shall publish proposed mandatory health and safety standards in the Federal Register and shall afford interested persons a period of not less than thirty days after publication to submit written data or comments. In the case of mandatory safety standards, except as provided in subsection (f) of this section, the Secretary may, upon the expiration of such period and after consideration of all relevant matter presented, promulgate such standards with such modifications as he may deem appropriate. In the case of mandatory health standards, except as provided in subsection (f) of this section, the Secretary of Health, Education, and Welfare may, upon the expiration of such period and after consideration of all relevant matter presented to the Secretary and transmitted to the Secretary of Health, Education, and Welfare, direct the Secretary to promulgate such standards with such modifications as the Secretary of Health, Education, and Welfare may deem appropriate and the Secretary shall thereupon promulgate such standards.

(f) On or before the last day of any period fixed for the submission of written data or comments under subsection (e) of this section, any interested person may file with the Secretary written objections to a proposed mandatory health or safety standard, stating the grounds therefor and requesting a public hearing on such objections. As soon as practicable after the period for filing such objections has expired, the Secretary shall publish in the Federal Register a notice specifying the proposed mandatory health or safety standards to which objections have been filed and a hearing requested.

Publication in
Federal
Register.

Publication in
Federal
Register.

Objections.

Publication in
Federal
Register.

(g) Promptly after any such notice is published in the Federal Register by the Secretary under subsection (f) of this section, the Secretary, in the case of mandatory safety standards, or the Secretary of Health, Education, and Welfare, in the case of mandatory health standards, shall issue notice of, and hold, a public hearing for the purpose of receiving relevant evidence. Within sixty days after completion of the hearings, the Secretary who held the hearing shall make findings of fact which shall be public. In the case of mandatory safety standards, the Secretary may promulgate such standards with such modifications as he deems appropriate. In the case of mandatory health standards, the Secretary of Health, Education, and Welfare may direct the Secretary to promulgate the mandatory health standards with such modifications as the Secretary of Health, Education, and Welfare deems appropriate and the Secretary shall thereupon promulgate the mandatory health standards. In the event the Secretary or the Secretary of Health, Education, and Welfare, as the case may be, determines that a proposed mandatory health or safety standard should not be promulgated or should be modified, he shall within a reasonable time publish his reasons for his determination.

Hearings.

(h) Any mandatory health or safety standard promulgated under this section shall be effective upon publication in the Federal Register unless the Secretary or the Secretary of Health, Education, and Welfare, as appropriate, specifies a later date.

Effective date.

(i) Proposed mandatory health and safety standards for surface coal mines shall be published by the Secretary, in accordance with the provisions of this section, not later than twelve months after the date of enactment of this Act. Proposed mandatory health and safety standards for surface work areas of underground coal mines, in addition to those established for such areas under this Act, shall be published by the Secretary, in accordance with the provisions of this section, not later than twelve months after the date of enactment of this Act.

(j) All interpretations, regulations, and instructions of the Secretary or the Director of the Bureau of Mines, in effect on the date of enactment of this Act and not inconsistent with any provision of this Act, shall be published in the Federal Register and shall continue in effect until modified or superseded in accordance with the provisions of this Act.

Publication in Federal Register.

(k) The Secretary shall send a copy of every proposed standard or regulation at the time of publication in the Federal Register to the operator of each coal mine and the representative of the miners at such mine and such copy shall be immediately posted on the bulletin board of the mine by the operator or his agent, but failure to receive such notice shall not relieve anyone of the obligation to comply with such standard or regulation.

Copies.

ADVISORY COMMITTEES

SEC. 102. (a) (1) The Secretary shall appoint an advisory committee on coal mine safety research composed of—

Committee on coal mine safety research, membership.

(A) the Director of the Office of Science and Technology, or his delegate, with the consent of the Director;

(B) the Director of the National Bureau of Standards, Department of Commerce, or his delegate, with the consent of the Director;

(C) the Director of the National Science Foundation, or his delegate, with the consent of the Director; and

(D) such other persons as the Secretary may appoint who are knowledgeable in the field of coal mine safety research. The Secretary shall designate the chairman of the committee.

(2) The advisory committee shall consult with, and make recommendations to, the Secretary on matters involving or relating to coal mine safety research. The Secretary shall consult with, and consider the recommendations of, such committee in the conduct of such research, the making of any grant, and the entering into of contracts for such research.

(3) The chairman of the committee and a majority of the persons appointed by the Secretary pursuant to paragraph (1) (D) of this subsection shall be individuals who have no economic interests in the coal mining industry, and who are not operators, miners, or officers or employees of the Federal Government or any State or local government.

(b) (1) The Secretary of Health, Education, and Welfare shall appoint an advisory committee on coal mine health research composed of—

(A) the Director, Bureau of Mines, or his delegate, with the consent of the Director;

(B) the Director of the National Science Foundation, or his delegate, with the consent of the Director;

(C) the Director of the National Institutes of Health, or his delegate, with the consent of the Director; and

(D) such other persons as the Secretary of Health, Education, and Welfare may appoint who are knowledgeable in the field of coal mine health research.

The Secretary of Health, Education, and Welfare shall designate the chairman of the committee.

(2) The advisory committee shall consult with, and make recommendations to, the Secretary of Health, Education, and Welfare on matters involving or relating to coal mine health research. The Secretary of Health, Education, and Welfare shall consult with, and consider the recommendations of, such committee in the conduct of such research, the making of any grant, and the entering into of contracts for such research.

(3) The chairman of the committee and a majority of the persons appointed by the Secretary of Health, Education, and Welfare pursuant to paragraph (1) (D) of this subsection shall be individuals who have no economic interests in the coal mining industry, and who are not operators, miners, or officers or employees of the Federal Government or any State or local government.

(c) The Secretary or the Secretary of Health, Education, and Welfare may appoint other advisory committees as he deems appropriate to advise him in carrying out the provisions of this Act. The Secretary or the Secretary of Health, Education, and Welfare, as the case may be, shall appoint the chairman of each such committee, who shall be an individual who has no economic interest in the coal mining industry, and who is not an operator, miner, or an officer or employee of the Federal Government or any State or local government. A majority of the members of any such advisory committee appointed pursuant to this subsection shall be composed of individuals who have no economic

Conflict of
interest.

Committee on
coal mine
health
research,
membership.

Conflict of
interest.

interests in the coal mining industry, and who are not operators, miners, or officers or employees of the Federal Government or any State or local government.

(d) Advisory committee members, other than officers or employees of Federal, State, or local governments, shall be, for each day (including traveltime) during which they are performing committee business, entitled to receive compensation at a rate fixed by the appropriate Secretary but not in excess of the maximum rate of pay for grade GS-18 as provided in the General Schedule under section 5332 of title 5 of the United States Code, and shall, notwithstanding the limitations of sections 5703 and 5704 of title 5 of the United States Code, be fully reimbursed for travel, subsistence, and related expenses.

Compensation
and travel
expenses.

34 F.R. 9605.
5 USC 5332
note.

Ante, p. 190.
80 Stat. 499.

INSPECTIONS AND INVESTIGATIONS

SEC. 103. (a) Authorized representatives of the Secretary shall make frequent inspections and investigations in coal mines each year for the purpose of (1) obtaining, utilizing, and disseminating information relating to health and safety conditions, the causes of accidents and the causes of diseases and physical impairments originating in such mines, (2) gathering information with respect to mandatory health or safety standards, (3) determining whether an imminent danger exists, and (4) determining whether or not there is compliance with the mandatory health or safety standards or with any notice, order, or decision issued under this title. In carrying out the requirements of clauses (3) and (4) of this subsection, no advance notice of an inspection shall be provided to any person. In carrying out the requirements of clauses (3) and (4) of this subsection in each underground coal mine, such representatives shall make inspections of the entire mine at least four times a year.

(b) (1) For the purpose of making any inspection or investigation under this Act, the Secretary or any authorized representative of the Secretary shall have a right of entry to, upon, or through any coal mine.

Right of
entry.

(2) For the purpose of developing improved mandatory health standards, the Secretary of Health, Education, and Welfare or his authorized representative shall have a right of entry to, upon, or through, any coal mine.

Right of
entry.

(3) The provisions of this Act relating to investigations and records shall be available to the Secretary of Health, Education, and Welfare to enable him to carry out his functions and responsibilities under this Act.

(c) For the purpose of carrying out his responsibilities under this Act, including the enforcement thereof, the Secretary may by agreement utilize with or without reimbursement the services, personnel, and facilities of any Federal agency.

(d) For the purpose of making any investigation of any accident or other occurrence relating to health or safety in a coal mine, the Secretary may, after notice, hold public hearings, and may sign and issue subpoenas for the attendance and testimony of witnesses and the production of relevant papers, books, and documents, and administer oaths. Witnesses summoned shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. In case of contumacy or refusal to obey a subpoena served upon any person under this section, the district court of the United States for any district in which such person is found or resides or transacts business, upon application by the United States and after notice to such person, shall

Hearings,
subpena power.

have jurisdiction to issue an order requiring such person to appear and give testimony before the Secretary or to appear and produce documents before the Secretary, or both, and any failure to obey such order of the court may be punished by such court as a contempt thereof.

(e) In the event of any accident occurring in a coal mine, the operator shall notify the Secretary thereof and shall take appropriate measures to prevent the destruction of any evidence which would assist in investigating the cause or causes thereof. In the event of any accident occurring in a coal mine where rescue and recovery work is necessary, the Secretary or an authorized representative of the Secretary shall take whatever action he deems appropriate to protect the life of any person, and he may, if he deems it appropriate, supervise and direct the rescue and recovery activity in such mine.

(f) In the event of any accident occurring in a coal mine, an authorized representative of the Secretary, when present, may issue such orders as he deems appropriate to insure the safety of any person in the coal mine, and the operator of such mine shall obtain the approval of such representative, in consultation with appropriate State representatives, when feasible, of any plan to recover any person in the mine or to recover the mine or to return affected areas of the mine to normal.

(g) Whenever a representative of the miners has reasonable grounds to believe that a violation of a mandatory health or safety standard exists, or an imminent danger exists, such representative shall have a right to obtain an immediate inspection by giving notice to the Secretary or his authorized representative of such violation or danger. Any such notice shall be reduced to writing, signed by the representative of the miners, and a copy shall be provided the operator or his agent no later than at the time of inspection, except that, upon the request of the person giving such notice, his name and the names of individual miners referred to therein shall not appear in such copy. Upon receipt of such notification, a special inspection shall be made as soon as possible to determine if such violation or danger exists in accordance with the provisions of this title.

(h) At the commencement of any inspection of a coal mine by an authorized representative of the Secretary, the authorized representative of the miners at the mine at the time of such inspection shall be given an opportunity to accompany the authorized representative of the Secretary on such inspection.

(i) Whenever the Secretary finds that a mine liberates excessive quantities of methane or other explosive gases during its operations, or that a methane or other gas ignition or explosion has occurred in such mine which resulted in death or serious injury at any time during the previous five years, or that there exists in such mine other especially hazardous conditions, he shall provide a minimum of one spot inspection by his authorized representative of all or part of such mine during every five working days at irregular intervals.

FINDINGS, NOTICES, AND ORDERS

SEC. 104. (a) If, upon any inspection of a coal mine, an authorized representative of the Secretary finds that an imminent danger exists, such representative shall determine the area throughout which such danger exists, and thereupon shall issue forthwith an order requiring the operator of the mine or his agent to cause immediately all persons,

except those referred to in subsection (d) of this section, to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such imminent danger no longer exists.

(b) Except as provided in subsection (i) of this section, if, upon any inspection of a coal mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard but the violation has not created an imminent danger, he shall issue a notice to the operator or his agent fixing a reasonable time for the abatement of the violation. If, upon the expiration of the period of time as originally fixed or subsequently extended, an authorized representative of the Secretary finds that the violation has not been totally abated, and if he also finds that the period of time should not be further extended, he shall find the extent of the area affected by the violation and shall promptly issue an order requiring the operator of such mine or his agent to cause immediately all persons, except those referred to in subsection (d) of this section, to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that the violation has been abated.

(c) (1) If, upon any inspection of a coal mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such nature as could significantly and substantially contribute to the cause and effect of a mine safety or health hazard, and if he finds such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory health or safety standards, he shall include such finding in any notice given to the operator under this Act. If, during the same inspection or any subsequent inspection of such mine within ninety days after the issuance of such notice, an authorized representative of the Secretary finds another violation of any mandatory health or safety standard and finds such violation to be also caused by an unwarrantable failure of such operator to so comply, he shall forthwith issue an order requiring the operator to cause all persons in the area affected by such violation, except those persons referred to in subsection (d) of this section, to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation has been abated.

(2) If a withdrawal order with respect to any area in a mine has been issued pursuant to paragraph (1) of this subsection, a withdrawal order shall promptly be issued by an authorized representative of the Secretary who finds upon any subsequent inspection the existence in such mine of violations similar to those that resulted in the issuance of the withdrawal order under paragraph (1) of this subsection until such time as an inspection of such mine discloses no similar violations. Following an inspection of such mine which discloses no similar violations, the provisions of paragraph (1) of this subsection shall again be applicable to that mine.

(d) The following persons shall not be required to be withdrawn from, or prohibited from entering, any area of the coal mine subject to an order issued under this section:

(1) any person whose presence in such area is necessary, in the judgment of the operator or an authorized representative of the Secretary, to eliminate the condition described in the order;

(2) any public official whose official duties require him to enter such area;

(3) any representative of the miners in such mine who is, in the judgment of the operator or an authorized representative of the Secretary, qualified to make coal mine examinations or who is accompanied by such a person and whose presence in such area is necessary for the investigation of the conditions described in the order; and

(4) any consultant to any of the foregoing.

(e) Notices and orders issued pursuant to this section shall contain a detailed description of the conditions or practices which cause and constitute an imminent danger or a violation of any mandatory health or safety standard and, where appropriate, a description of the area of the coal mine from which persons must be withdrawn and prohibited from entering.

(f) Each notice or order issued under this section shall be given promptly to the operator of the coal mine or his agent by an authorized representative of the Secretary issuing such notice or order, and all such notices and orders shall be in writing and shall be signed by such representative.

(g) A notice or order issued pursuant to this section, except an order issued under subsection (h) of this section, may be modified or terminated by an authorized representative of the Secretary.

(h) (1) If, upon any inspection of a coal mine, an authorized representative of the Secretary finds (A) that conditions exist therein which have not yet resulted in an imminent danger, (B) that such conditions cannot be effectively abated through the use of existing technology, and (C) that reasonable assurance cannot be provided that the continuance of mining operations under such conditions will not result in an imminent danger, he shall determine the area throughout which such conditions exist, and thereupon issue a notice to the operator of the mine or his agent of such conditions, and shall file a copy thereof, incorporating his findings therein, with the Secretary and with the representative of the miners of such mine. Upon receipt of such copy, the Secretary shall cause such further investigation to be made as he deems appropriate, including an opportunity for the operator or a representative of the miners to present information relating to such notice.

(2) Upon the conclusion of such investigation and an opportunity for a public hearing upon request by any interested party, the Secretary shall make findings of fact, and shall by decision incorporating such findings therein, either cancel the notice issued under this subsection or issue an order requiring the operator of such mine to cause all persons in the area affected, except those persons referred to in subsection (d) of this section, to be withdrawn from, and be prohibited from entering, such area until the Secretary, after a public hearing affording all interested persons an opportunity to present their views, determines that such conditions have been abated. Any hearing under this paragraph shall be of record and shall be subject to section 554 of title 5 of the United States Code.

(i) If, based upon samples taken and analyzed and recorded pursuant to section 202(a) of this Act, or samples taken during an inspection by an authorized representative of the Secretary, the applicable limit on the concentration of respirable dust required to be maintained under this Act is exceeded and thereby violated, the Secretary or his authorized representative shall issue a notice fixing a reasonable time for the abatement of the violation. During such time, the operator of

the mine shall cause samples described in section 202(a) of this Act to be taken of the affected area during each production shift. If, upon the expiration of the period of time as originally fixed or subsequently extended, the Secretary or his authorized representative finds that the period of time should not be further extended, he shall find the extent of the area affected by the violation and shall promptly issue an order requiring the operator of such mine or his agent to cause immediately all persons, except those referred to in subsection (d) of this section, to be withdrawn from, and to be prohibited from entering, such area until the Secretary or his authorized representative has reason to believe, based on actions taken by the operator, that such limit will be complied with upon the resumption of production in such mine. As soon as possible after an order is issued, the Secretary, upon request of the operator, shall dispatch to the mine involved a person or team of persons, to the extent such persons are available, who are knowledgeable in the methods and means of controlling and reducing respirable dust. Such person or team of persons shall remain at the mine involved for such time as they shall deem appropriate to assist the operator in reducing respirable dust concentrations. While at the mine, such persons may require the operator to take such actions as they deem appropriate to insure the health of any person in the coal mine.

Post, p. 760.

REVIEW BY THE SECRETARY

SEC. 105. (a) (1) An operator issued an order pursuant to the provisions of section 104 of this title, or any representative of miners in any mine affected by such order or by any modification or termination of such order, may apply to the Secretary for review of the order within thirty days of receipt thereof or within thirty days of its modification or termination. An operator issued a notice pursuant to section 104(b) or (i) of this title, or any representative of miners in any mine affected by such notice, may, if he believes that the period of time fixed in such notice for the abatement of the violation is unreasonable, apply to the Secretary for review of the notice within thirty days of the receipt thereof. The applicant shall send a copy of such application to the representative of miners in the affected mine, or the operator, as appropriate. Upon receipt of such application, the Secretary shall cause such investigation to be made as he deems appropriate. Such investigation shall provide an opportunity for a public hearing, at the request of the operator or the representative of miners in such mine, to enable the operator and the representative of miners in such mine to present information relating to the issuance and continuance of such order or the modification or termination thereof or to the time fixed in such notice. The filing of an application for review under this subsection shall not operate as a stay of any order or notice.

Hearing.

(2) The operator and the representative of the miners shall be given written notice of the time and place of the hearing at least five days prior to the hearing. Any such hearing shall be of record and shall be subject to section 554 of title 5 of the United States Code.

80 Stat. 384.

(b) Upon receiving the report of such investigation, the Secretary shall make findings of fact, and he shall issue a written decision, incorporating therein an order vacating, affirming, modifying, or terminating the order, or the modification or termination of such order, or the notice, complained of and incorporate his findings therein.

(c) In view of the urgent need for prompt decision of matters submitted to the Secretary under this section, all actions which the Secretary takes under this section shall be taken as promptly as practicable, consistent with adequate consideration of the issues involved.

(d) Pending completion of the investigation required by this section, the applicant may file with the Secretary a written request that the Secretary grant temporary relief (1) from any modification or termination of any order, or (2) from any order issued under section 104 of this title, except an order issued under section 104(a) of this title, together with a detailed statement giving reasons for granting such relief. The Secretary may grant such relief, under such conditions as he may prescribe, if—

(1) a hearing has been held in which all parties were given an opportunity to be heard;

(2) the applicant shows that there is substantial likelihood that the findings of the Secretary will be favorable to the applicant; and

(3) such relief will not adversely affect the health and safety of miners in the coal mine.

No temporary relief shall be granted in the case of a notice issued under section 104 (b) or (i) of this title.

JUDICIAL REVIEW

Sec. 106. (a) Any order or decision issued by the Secretary or the Panel under this Act, except an order or decision under section 109(a) of this Act, shall be subject to judicial review by the United States court of appeals for the circuit in which the affected mine is located, or the United States Court of Appeals for the District of Columbia Circuit, upon the filing in such court within thirty days from the date of such order or decision of a petition by any person aggrieved by the order or decision praying that the order or decision be modified or set aside in whole or in part, except that the court shall not consider such petition unless such person has exhausted the administrative remedies available under this Act. A copy of the petition shall forthwith be sent by registered or certified mail to the other party and to the Secretary or the Panel, and thereupon the Secretary or the Panel shall certify and file in such court the record upon which the order or decision complained of was issued, as provided in section 2112 of title 28, United States Code.

(b) The court shall hear such petition on the record made before the Secretary or the Panel. The findings of the Secretary or the Panel, if supported by substantial evidence on the record considered as a whole, shall be conclusive. The court may affirm, vacate, or modify any order or decision or may remand the proceedings to the Secretary or the Panel for such further action as it may direct.

(c) (1) In the case of a proceeding to review any order or decision issued by the Secretary under this Act, except an order or decision pertaining to an order issued under section 104(a) of this title or an order or decision pertaining to a notice issued under section 104 (b) or (i) of this title, the court may, under such conditions as it may prescribe, grant such temporary relief as it deems appropriate pending final determination of the proceeding if—

(A) all parties to the proceeding have been notified and given an opportunity to be heard on a request for temporary relief;

(B) the person requesting such relief shows that there is a substantial likelihood that he will prevail on the merits of the final determination of the proceeding; and

(C) such relief will not adversely affect the health and safety of miners in the coal mine.

(2) In the case of a proceeding to review any order or decision issued by the Panel under this Act, the court may, under such condi-

tions as it may prescribe, grant such temporary relief as it deems appropriate pending final determination of the proceeding if—

(A) all parties to the proceeding have been notified and given an opportunity to be heard on a request for temporary relief; and

(B) the person requesting such relief shows that there is a substantial likelihood that he will prevail on the merits of the final determination of the proceeding.

(d) The judgment of the court shall be subject to review only by the Supreme Court of the United States upon a writ of certiorari or certification as provided in section 1254 of title 28, United States Code.

62 Stat. 928.

(e) The commencement of a proceeding under this section shall not, unless specifically ordered by the court, operate as a stay of the order or decision of the Secretary or the Panel.

(f) Subject to the direction and control of the Attorney General, as provided in section 507(b) of title 28 of the United States Code, attorneys appointed by the Secretary may appear for and represent him in any proceeding instituted under this section.

80 Stat. 663.

POSTING OF NOTICES, ORDERS, AND DECISIONS

SEC. 107. (a) At each coal mine there shall be maintained an office with a conspicuous sign designating it as the office of the mine, and a bulletin board at such office or at some conspicuous place near an entrance of the mine, in such manner that notices, orders, and decisions required by law or regulation to be posted on the mine bulletin board may be posted thereon, be easily visible to all persons desiring to read them, and be protected against damage by weather and against unauthorized removal. A copy of any notice, order, or decision required by this title to be given to an operator shall be delivered to the office of the affected mine, and a copy shall be immediately posted on the bulletin board of such mine by the operator or his agent.

(b) The Secretary shall cause a copy of any notice, order, or decision required by this Act to be given to an operator to be mailed immediately to a representative of the miners in the affected mine, and to the public official or agency of the State charged with administering State laws, if any, relating to health or safety in such mine. Such notice, order, or decision shall be available for public inspection.

(c) In order to insure prompt compliance with any notice, order, or decision issued under this Act, the authorized representative of the Secretary may deliver such notice, order, or decision to an agent of the operator and such agent shall immediately take appropriate measures to insure compliance with such notice, order, or decision.

(d) Each operator of a coal mine shall file with the Secretary the name and address of such mine and the name and address of the person who controls or operates the mine. Any revisions in such names or addresses shall be promptly filed with the Secretary. Each operator of a coal mine shall designate a responsible official at such mine as the principal officer in charge of health and safety at such mine and such official shall receive a copy of any notice, order, or decision issued under this Act affecting such mine. In any case, where the coal mine is subject to the control of any person not directly involved in the daily operations of the coal mine, there shall be filed with the Secretary the name and address of such person and the name and address of a principal official of such person who shall have overall responsibility for the conduct of an effective health and safety program at any coal mine subject to the control of such person and such official shall

receive a copy of any notice, order, or decision issued affecting any such mine. The mere designation of a health and safety official under this subsection shall not be construed as making such official subject to any penalty under this Act.

INJUNCTIONS

SEC. 108. The Secretary may institute a civil action for relief, including a permanent or temporary injunction, restraining order, or any other appropriate order in the district court of the United States for the district in which a coal mine is located or in which the operator of such mine has his principal office, whenever such operator or his agent (a) violates or fails or refuses to comply with any order or decision issued under this Act, or (b) interferes with, hinders, or delays the Secretary or his authorized representative, or the Secretary of Health, Education, and Welfare or his authorized representative, in carrying out the provisions of this Act, or (c) refuses to admit such representatives to the mine, or (d) refuses to permit the inspection of the mine, or the investigation of an accident or occupational disease occurring in, or connected with, such mine, or (e) refuses to furnish any information or report requested by the Secretary or the Secretary of Health, Education, and Welfare in furtherance of the provisions of this Act, or (f) refuses to permit access to, and copying of, such records as the Secretary or the Secretary of Health, Education, and Welfare determines necessary in carrying out the provisions of this Act. Each court shall have jurisdiction to provide such relief as may be appropriate. Temporary restraining orders shall be issued in accordance with Rule 65 of the Federal Rules of Civil Procedure, as amended, except that the time limit in such orders, when issued without notice, shall be seven days from the date of entry. Except as otherwise provided herein, any relief granted by the court to enforce an order under clause (a) of this section shall continue in effect until the completion or final termination of all proceedings for review of such order under this title, unless, prior thereto, the district court granting such relief sets it aside or modifies it. In actions under this section, subject to the direction and control of the Attorney General, as provided in section 507(b) of title 28 of the United States Code, attorneys appointed by the Secretary may appear for and represent him. In any action instituted under this section to enforce an order or decision issued by the Secretary after a public hearing in accordance with section 554 of title 5 of the United States Code, the findings of the Secretary, if supported by substantial evidence on the record considered as a whole, shall be conclusive.

PENALTIES

SEC. 109. (a) (1) The operator of a coal mine in which a violation occurs of a mandatory health or safety standard or who violates any other provision of this Act, except the provisions of title 4, shall be assessed a civil penalty by the Secretary under paragraph (3) of this subsection which penalty shall not be more than \$10,000 for each such violation. Each occurrence of a violation of a mandatory health or safety standard may constitute a separate offense. In determining the amount of the penalty, the Secretary shall consider the operator's history of previous violations, the appropriateness of such penalty to

28 USC app.

80 Stat. 663.

80 Stat. 384.

Post, p. 792.

the size of the business of the operator charged, whether the operator was negligent, the effect on the operator's ability to continue in business, the gravity of the violation, and the demonstrated good faith of the operator charged in attempting to achieve rapid compliance after notification of a violation.

(2) Any miner who willfully violates the mandatory safety standards relating to smoking or the carrying of smoking materials, matches, or lighters shall be subject to a civil penalty assessed by the Secretary under paragraph (3) of this subsection, which penalty shall not be more than \$250 for each occurrence of such violation.

(3) A civil penalty shall be assessed by the Secretary only after the person charged with a violation under this Act has been given an opportunity for a public hearing and the Secretary has determined, by decision incorporating his findings of fact therein, that a violation did occur, and the amount of the penalty which is warranted, and incorporating, when appropriate, an order therein requiring that the penalty be paid. Where appropriate, the Secretary shall consolidate such hearings with other proceedings under section 105 of this title. Any hearing under this section shall be of record and shall be subject to section 554 of title 5 of the United States Code.

80 Stat. 384.

(4) If the person against whom a civil penalty is assessed fails to pay the penalty within the time prescribed in such order, the Secretary shall file a petition for enforcement of such order in any appropriate district court of the United States. The petition shall designate the person against whom the order is sought to be enforced as the respondent. A copy of the petition shall forthwith be sent by registered or certified mail to the respondent and to the representative of the miners in the affected mine or the operator, as the case may be, and thereupon the Secretary shall certify and file in such court the record upon which such order sought to be enforced was issued. The court shall have jurisdiction to enter a judgment enforcing, modifying, and enforcing as so modified, or setting aside in whole or in part the order and decision of the Secretary or it may remand the proceedings to the Secretary for such further action as it may direct. The court shall consider and determine de novo all relevant issues, except issues of fact which were or could have been litigated in review proceedings before a court of appeals under section 106 of this Act, and upon the request of the respondent, such issues of fact which are in dispute shall be submitted to a jury. On the basis of the jury's findings, the court shall determine the amount of the penalty to be imposed. Subject to the direction and control of the Attorney General, as provided in section 507(b) of title 28 of the United States Code, attorneys appointed by the Secretary may appear for and represent him in any action to enforce an order assessing civil penalties under this paragraph.

80 Stat. 663.

(b) Any operator who willfully violates a mandatory health or safety standard, or knowingly violates or fails or refuses to comply with any order issued under section 104 of this title, or any order incorporated in a final decision issued under this title, except an order incorporated in a decision under subsection (a) of this section or section 110(b)(2) of this title, shall, upon conviction, be punished by a fine of not more than \$25,000, or by imprisonment for not more than one year, or by both, except that if the conviction is for a violation committed after the first conviction of such operator under this Act, punishment shall be by a fine of not more than \$50,000, or by imprisonment for not more than five years, or by both.

(c) Whenever a corporate operator violates a mandatory health or safety standard or knowingly violates or fails or refuses to comply with any order issued under this Act or any order incorporated in a final decision issued under this Act, except an order incorporated in a decision issued under subsection (a) of this section or section 110 (b) (2) of this title, any director, officer, or agent of such corporation who knowingly authorized, ordered, or carried out such violation, failure, or refusal shall be subject to the same civil penalties, fines, and imprisonment that may be imposed upon a person under subsections (a) and (b) of this section.

(d) Whoever knowingly makes any false statement, representation, or certification in any application, record, report, plan, or other document filed or required to be maintained pursuant to this Act or any order or decision issued under this Act shall, upon conviction, be punished by a fine of not more than \$10,000, or by imprisonment for not more than six months, or by both.

(e) Whoever knowingly distributes, sells, offers for sale, introduces, or delivers in commerce any equipment for use in a coal mine, including, but not limited to, components and accessories of such equipment, which is represented as complying with the provisions of this Act, or with any specification or regulation of the Secretary applicable to such equipment, and which does not so comply, shall, upon conviction, be subject to the same fine and imprisonment that may be imposed upon a person under subsection (d) of this section.

ENTITLEMENT OF MINERS

SEC. 110. (a) If a coal mine or area of a coal mine is closed by an order issued under section 104 of this title, all miners working during the shift when such order was issued who are idled by such order shall be entitled to full compensation by the operator at their regular rates of pay for the period they are idled, but for not more than the balance of such shift. If such order is not terminated prior to the next working shift, all miners on that shift who are idled by such order shall be entitled to full compensation by the operator at their regular rates of pay for the period they are idled, but for not more than four hours of such shift. If a coal mine or area of a coal mine is closed by an order issued under section 104 of this title for an unwarrantable failure of the operator to comply with any health or safety standard, all miners who are idled due to such order shall be fully compensated, after all interested parties are given an opportunity for a public hearing on such compensation and after such order is final, by the operator for lost time at their regular rates of pay for such time as the miners are idled by such closing, or for one week, whichever is the lesser. Whenever an operator violates or fails or refuses to comply with any order issued under section 104 of this Act, all miners employed at the affected mine who would be withdrawn from, or prevented from entering, such mine or area thereof as a result of such order shall be entitled to full compensation by the operator at their regular rates of pay, in addition to pay received for work performed after such order was issued, for the period beginning when such order was issued and ending when such order is complied with, vacated, or terminated.

(b) (1) No person shall discharge or in any other way discriminate against or cause to be discharged or discriminated against any miner or any authorized representative of miners by reason of the fact that such miner or representative (A) has notified the Secretary or his authorized representative of any alleged violation or danger, (B) has

Compensation.

Discrimination.

filed, instituted, or caused to be filed or instituted any proceeding under this Act, or (C) has testified or is about to testify in any proceeding resulting from the administration or enforcement of the provisions of this Act.

(2) Any miner or a representative of miners who believes that he has been discharged or otherwise discriminated against by any person in violation of paragraph (1) of this subsection may, within thirty days after such violation occurs, apply to the Secretary for a review of such alleged discharge or discrimination. A copy of the application shall be sent to such person who shall be the respondent. Upon receipt of such application, the Secretary shall cause such investigation to be made as he deems appropriate. Such investigation shall provide an opportunity for a public hearing at the request of any party to enable the parties to present information relating to such violation. The parties shall be given written notice of the time and place of the hearing at least five days prior to the hearing. Any such hearing shall be of record and shall be subject to section 554 of title 5 of the United States Code. Upon receiving the report of such investigation, the Secretary shall make findings of fact. If he finds that such violation did occur, he shall issue a decision, incorporating an order therein, requiring the person committing such violation to take such affirmative action to abate the violation as the Secretary deems appropriate, including, but not limited to, the rehiring or reinstatement of the miner or representative of miners to his former position with back pay. If he finds that there was no such violation, he shall issue an order denying the application. Such order shall incorporate the Secretary's findings therein. Any order issued by the Secretary under this paragraph shall be subject to judicial review in accordance with section 106 of this Act. Violations by any person of paragraph (1) of this subsection shall be subject to the provisions of sections 108 and 109 (a) of this title.

80 Stat. 384.

(3) Whenever an order is issued under this subsection, at the request of the applicant, a sum equal to the aggregate amount of all costs and expenses (including the attorney's fees) as determined by the Secretary to have been reasonably incurred by the applicant for, or in connection with, the institution and prosecution of such proceedings, shall be assessed against the person committing such violation.

REPORTS

SEC. 111. (a) All accidents, including unintentional roof falls (except in any abandoned panels or in areas which are inaccessible or unsafe for inspections), shall be investigated by the operator or his agent to determine the cause and the means of preventing a recurrence. Records of such accidents, roof falls, and investigations shall be kept and the information shall be made available to the Secretary or his authorized representative and the appropriate State agency. Such records shall be open for inspection by interested persons. Such records shall include man-hours worked and shall be reported for periods determined by the Secretary, but at least annually.

(b) In addition to such records as are specifically required by this Act, every operator of a coal mine shall establish and maintain such records, make such reports, and provide such information, as the Secretary may reasonably require from time to time to enable him to perform his functions under this Act. The Secretary is authorized to compile, analyze, and publish, either in summary or detailed form, such reports or information so obtained. Except to the extent other-

Records,
availability.

wise specifically provided by this Act, all records, information, reports, findings, notices, orders, or decisions required or issued pursuant to or under this Act may be published from time to time, may be released to any interested person, and shall be made available for public inspection.

TITLE II—INTERIM MANDATORY HEALTH STANDARDS

COVERAGE

Post, p. 791.

Ante, p. 745.

SEC. 201. (a) The provisions of sections 202 through 206 of this title and the applicable provisions of section 318 of title III shall be interim mandatory health standards applicable to all underground coal mines until superseded in whole or in part by improved mandatory health standards promulgated by the Secretary under the provisions of section 101 of this Act, and shall be enforced in the same manner and to the same extent as any mandatory health standard promulgated under the provisions of section 101 of this Act. Any orders issued in the enforcement of the interim standards set forth in this title shall be subject to review as provided in title I of this Act.

(b) Among other things, it is the purpose of this title to provide, to the greatest extent possible, that the working conditions in each underground coal mine are sufficiently free of respirable dust concentrations in the mine atmosphere to permit each miner the opportunity to work underground during the period of his entire adult working life without incurring any disability from pneumoconiosis or any other occupation-related disease during or at the end of such period.

DUST STANDARD AND RESPIRATORY EQUIPMENT

SEC. 202. (a) Each operator of a coal mine shall take accurate samples of the amount of respirable dust in the mine atmosphere to which each miner in the active workings of such mine is exposed. Such samples shall be taken by any device approved by the Secretary and the Secretary of Health, Education, and Welfare and in accordance with such methods, at such locations, at such intervals, and in such manner as the Secretaries shall prescribe in the Federal Register within sixty days from the date of enactment of this Act and from time to time thereafter. Such samples shall be transmitted to the Secretary in a manner established by him, and analyzed and recorded by him in a manner that will assure application of the provisions of section 104(i) of this Act when the applicable limit on the concentration of respirable dust required to be maintained under this section is exceeded. The results of such samples shall also be made available to the operator. Each operator shall report and certify to the Secretary at such intervals as the Secretary may require as to the conditions in the active workings of the coal mine, including, but not limited to, the average number of working hours worked during each shift, the quantity and velocity of air regularly reaching the working faces, the method of mining, the amount and pressure of the water, if any, reaching the working faces, and the number, location, and type of sprays, if any, used.

(b) Except as otherwise provided in this subsection—

(1) Effective on the operative date of this title, each operator shall continuously maintain the average concentration of respira-

ble dust in the mine atmosphere during each shift to which each miner in the active workings of such mine is exposed at or below 3.0 milligrams of respirable dust per cubic meter of air.

(2) Effective three years after the date of enactment of this Act, each operator shall continuously maintain the average concentration of respirable dust in the mine atmosphere during each shift to which each miner in the active workings of such mine is exposed at or below 2.0 milligrams of respirable dust per cubic meter of air.

(3) Any operator who determines that he will be unable, using available technology, to comply with the provisions of paragraph (1) of this subsection, or the provisions of paragraph (2) of this subsection, as appropriate, may file with the Panel, no later than sixty days prior to the effective date of the applicable respirable dust standard established by such paragraphs, an application for a permit for noncompliance. If, in the case of an application for a permit for noncompliance with the 3.0 milligram standard established by paragraph (1) of this subsection, the application satisfies the requirements of subsection (c) of this section, the Panel shall issue a permit for noncompliance to the operator. If, in the case of an application for a permit for noncompliance with the 2.0 milligram standard established by paragraph (2) of this subsection, the application satisfies the requirements of subsection (c) of this section and the Panel determines that the applicant will be unable to comply with such standard, the Panel shall issue to the operator a permit for noncompliance.

Noncompliance
permit.

(4) In any case in which an operator, who has been issued a permit (including a renewal permit) for noncompliance under this section, determines, not more than ninety days prior to the expiration date of such permit, that he still is unable to comply with the standard established by paragraph (1) of this subsection or the standard established by paragraph (2) of this subsection, as appropriate, he may file with the Panel an application for renewal of the permit. Upon receipt of such application, the Panel, if it determines, after all interested persons have been notified and given an opportunity for a public hearing under section 5 of this Act, that the application is in compliance with the provisions of subsection (c) of this section, and that the applicant will be unable to comply with such standard, may renew the permit.

Permit
renewal.

(5) Any such permit or renewal thereof so issued shall be in effect for a period not to exceed one year and shall entitle the permittee during such period to maintain continuously the average concentration of respirable dust in the mine atmosphere during each shift in the working places of such mine to which the permit applies at a level specified by the Panel, which shall be at the lowest level which the application shows the conditions, technology applicable to such mine, and other available and effective control techniques and methods will permit, but in no event shall such level exceed 4.5 milligrams of dust per cubic meter of air during the period when the 3.0 milligram standard is in effect, or 3.0 milligrams of dust per cubic meter of air during the period when the 2.0 milligram standard is in effect.

Ante, p. 744.

Permit
termination.

(6) No permit or renewal thereof for noncompliance shall

entitle any operator to an extension of time beyond eighteen months from the date of enactment of this Act to comply with the 3.0 milligram standard established by paragraph (1) of this subsection, or beyond seventy-two months from the date of enactment of this Act to comply with the 2.0 milligram standard established by paragraph (2) of this subsection.

(c) Any application for an initial or renewal permit made pursuant to this section shall contain—

(1) a representation by the applicant and the engineer conducting the survey referred to in paragraph (2) of this subsection that the applicant is unable to comply with the standard applicable under subsection (b) (1) or (b) (2) of this section at specified working places because the technology for reducing the concentration of respirable dust at such places is not available, or because of the lack of other effective control techniques or methods, or because of any combination of such reasons;

(2) an identification of the working places in such mine for which the permit is requested; the results of an engineering survey by a certified engineer of the respirable dust conditions of each working place of the mine with respect to which such application is filed and the ability to reduce such dust to the level required to be maintained in such place under this section; a description of the ventilation system of the mine and its capacity; the quantity and velocity of air regularly reaching the working faces; the method of mining; the amount and pressure of the water, if any, reaching the working faces; the number, location, and type of sprays, if any; action taken to reduce such dust; and such other information as the Panel may require; and

(3) statements by the applicant and the engineer conducting such survey, of the means and methods to be employed to achieve compliance with the applicable standard, the progress made toward achieving compliance, and an estimate of when compliance can be achieved.

(d) Beginning six months after the operative date of this title and from time to time thereafter, the Secretary of Health, Education, and Welfare shall establish, in accordance with the provisions of section 101 of this Act, a schedule reducing the average concentration of respirable dust in the mine atmosphere during each shift to which each miner in the active workings is exposed below the levels established in this section to a level of personal exposure which will prevent new incidences of respiratory disease and the further development of such disease in any person. Such schedule shall specify the minimum time necessary to achieve such levels taking into consideration present and future advancements in technology to reach these levels.

(e) References to concentrations of respirable dust in this title means the average concentration of respirable dust if measured with an MRE instrument or such equivalent concentrations if measured with another device approved by the Secretary and the Secretary of Health, Education, and Welfare. As used in this title, the term "MRE instrument" means the gravimetric dust sampler with four channel horizontal elutriator developed by the Mining Research Establishment of the National Coal Board, London, England.

(f) For the purpose of this title, the term "average concentration" means a determination which accurately represents the atmospheric conditions with regard to respirable dust to which each miner in the active workings of a mine is exposed (1) as measured, during the 18

Reduction
schedule,
establishment.
Ante, p. 745.

"MRE
instrument."

"Average
concentration."

month period following the date of enactment of this Act, over a number of continuous production shifts to be determined by the Secretary and the Secretary of Health, Education, and Welfare, and (2) as measured thereafter, over a single shift only, unless the Secretary and the Secretary of Health, Education, and Welfare find, in accordance with the provisions of section 101 of this Act, that such single shift measurement will not, after applying valid statistical techniques to such measurement, accurately represent such atmospheric conditions during such shift.

Ante, p. 745.

(g) The Secretary shall cause to be made such frequent spot inspections as he deems appropriate of the active workings of coal mines for the purpose of obtaining compliance with the provisions of this title.

Spot
inspection.

(h) Respiratory equipment approved by the Secretary and the Secretary of Health, Education, and Welfare shall be made available to all persons whenever exposed to concentrations of respirable dust in excess of the levels required to be maintained under this Act. Use of respirators shall not be substituted for environmental control measures in the active workings. Each operator shall maintain a supply of respiratory equipment adequate to deal with occurrences of concentrations of respirable dust in the mine atmosphere in excess of the levels required to be maintained under this Act.

MEDICAL EXAMINATIONS

SEC. 203 (a) The operator of a coal mine shall cooperate with the Secretary of Health, Education, and Welfare in making available to each miner working in a coal mine the opportunity to have a chest roentgenogram within eighteen months after the date of enactment of this Act, a second chest roentgenogram within three years thereafter, and subsequent chest roentgenograms at such intervals thereafter of not to exceed five years as the Secretary of Health, Education, and Welfare prescribes. Each worker who begins work in a coal mine for the first time shall be given, as soon as possible after commencement of his employment, and again three years later if he is still engaged in coal mining, a chest roentgenogram; and in the event the second such chest roentgenogram shows evidence of the development of pneumoconiosis the worker shall be given, two years later if he is still engaged in coal mining, an additional chest roentgenogram. All chest roentgenograms shall be given in accordance with specifications prescribed by the Secretary of Health, Education, and Welfare and shall be supplemented by such other tests as the Secretary of Health, Education, and Welfare deems necessary. The films shall be read and classified in a manner to be prescribed by the Secretary of Health, Education, and Welfare, and the results of each reading on each such person and of such tests shall be submitted to the Secretary and to the Secretary of Health, Education, and Welfare, and, at the request of the miner, to his physician. The Secretary shall also submit such results to such miner and advise him of his rights under this Act related thereto. Such specifications, readings, classifications, and tests shall, to the greatest degree possible, be uniform for all coal mines and miners in such mines.

(b)(1) On and after the operative date of this title, any miner who, in the judgment of the Secretary of Health, Education, and Welfare based upon such reading or other medical examinations, shows

evidence of the development of pneumoconiosis shall be afforded the option of transferring from his position to another position in any area of the mine, for such period or periods as may be necessary to prevent further development of such disease, where the concentration of respirable dust in the mine atmosphere is not more than 2.0 milligrams of dust per cubic meter of air.

(2) Effective three years after the date of enactment of this Act, any miner who, in the judgment of the Secretary of Health, Education, and Welfare based upon such reading or other medical examinations, shows evidence of the development of pneumoconiosis shall be afforded the option of transferring from his position to another position in any area of the mine, for such period or periods as may be necessary to prevent further development of such disease, where the concentration of respirable dust in the mine atmosphere is not more than 1.0 milligrams of dust per cubic meter of air, or if such level is not attainable in such mine, to a position in such mine where the concentration of respirable dust is the lowest attainable below 2.0 milligrams per cubic meter of air.

(3) Any miner so transferred shall receive compensation for such work at not less than the regular rate of pay received by him immediately prior to his transfer.

(c) No payment may be required of any miner in connection with any examination or test given him pursuant to this title. Where such examinations or tests cannot be given, due to the lack of adequate medical or other necessary facilities or personnel, in the locality where the miner resides, arrangements shall be made to have them conducted, in accordance with the provisions of this title, in such locality by the Secretary of Health, Education, and Welfare, or by an appropriate person, agency, or institution, public or private, under an agreement or arrangement between the Secretary of Health, Education, and Welfare and such person, agency, or institution. The operator of the mine shall reimburse the Secretary of Health, Education, and Welfare, or such person, agency, or institution, as the case may be, for the cost of conducting each examination or test made, in accordance with this title, and shall pay whatever other costs are necessary to enable the miner to take such examinations or tests.

Autopsy.

(d) If the death of any active miner occurs in any coal mine, or if the death of any active or inactive miner occurs in any other place, the Secretary of Health, Education, and Welfare is authorized to provide for an autopsy to be performed on such miner, with the consent of his surviving widow or, if he has no such widow, then with the consent of his surviving next of kin. The results of such autopsy shall be submitted to the Secretary of Health, Education, and Welfare and, with the consent of such survivor, to the miner's physician or other interested person. Such autopsy shall be paid for by the Secretary of Health, Education, and Welfare.

DUST FROM DRILLING ROCK

SEC. 204. The dust resulting from drilling in rock shall be controlled by the use of permissible dust collectors, or by water or water with a wetting agent, or by ventilation, or by any other method or device approved by the Secretary which is at least as effective in controlling such dust. Respiratory equipment approved by the Secretary and the Secretary of Health, Education, and Welfare shall be provided per-

sons exposed for short periods to inhalation hazards from gas, dusts, fumes, or mist. When the exposure is for prolonged periods, other measures to protect such persons or to reduce the hazard shall be taken.

DUST STANDARD WHEN QUARTZ IS PRESENT

SEC. 205. In coal mining operations where the concentration of respirable dust in the mine atmosphere of any working place contains more than 5 per centum quartz, the Secretary of Health, Education, and Welfare shall prescribe an appropriate formula for determining the applicable respirable dust standard under this title for such working place and the Secretary shall apply such formula in carrying out his duties under this title.

NOISE STANDARD

SEC. 206. On and after the operative date of this title, the standards on noise prescribed under the Walsh-Healey Public Contracts Act, as amended, in effect October 1, 1969, shall be applicable to each coal mine and each operator of such mine shall comply with them. Within six months after the date of enactment of this Act, the Secretary of Health, Education, and Welfare shall establish, and the Secretary shall publish, as provided in section 101 of this Act, proposed mandatory health standards establishing maximum noise exposure levels for all underground coal mines. Beginning six months after the operative date of this title, and at intervals of at least every six months thereafter, the operator of each coal mine shall conduct, in a manner prescribed by the Secretary of Health, Education, and Welfare, tests by a qualified person of the noise level at the mine and report and certify the results to the Secretary and the Secretary of Health, Education, and Welfare. In meeting such standard under this section, the operator shall not require the use of any protective device or system, including personal devices, which the Secretary or his authorized representative finds to be hazardous or cause a hazard to the miners in such mine.

49 Stat. 2036.
41 USC 35
note.

Ante, p. 745.

TITLE III—INTERIM MANDATORY SAFETY STANDARDS FOR UNDERGROUND COAL MINES

COVERAGE

SEC. 301. (a) The provisions of sections 302 through 318 of this title shall be interim mandatory safety standards applicable to all underground coal mines until superseded in whole or in part by improved mandatory safety standards promulgated by the Secretary under the provisions of section 101 of this Act, and shall be enforced in the same manner and to the same extent as any mandatory safety standard promulgated under section 101 of this Act. Any orders issued in the enforcement of the interim standards set forth in this title shall be subject to review as provided in title I of this Act.

(b) The purpose of this title is to provide for the immediate application of mandatory safety standards developed on the basis of experience and advances in technology and to prevent newly created hazards resulting from new technology in coal mining. The Secretary shall immediately initiate studies, investigations, and research to further upgrade such standards and to develop and promulgate new and

improved standards promptly that will provide increased protection to the miners, particularly in connection with hazards from trolley wires, trolley feeder wires, and signal wires, the splicing and use of trailing cables, and in connection with improvements in vulcanizing of electric conductors, improvement in roof control measures, methane drainage in advance of mining, improved methods of measuring methane and other explosive gases and oxygen concentrations, and the use of improved underground equipment and other sources of power for such equipment.

Modifications.

(c) Upon petition by the operator or the representative of miners, the Secretary may modify the application of any mandatory safety standard to a mine if the Secretary determines that an alternative method of achieving the result of such standard exists which will at all times guarantee no less than the same measure of protection afforded the miners of such mine by such standard, or that the application of such standard to such mine will result in a diminution of safety to the miners in such mine. Upon receipt of such petition the Secretary shall publish notice thereof and give notice to the operator or the representative of miners in the affected mine, as appropriate, and shall cause such investigation to be made as he deems appropriate. Such investigation shall provide an opportunity for a public hearing, at the request of such operator or representative or other interested party, to enable the operator and the representative of miners in such mine or other interested party to present information relating to the modification of such standard. The Secretary shall issue a decision incorporating his findings of fact therein, and send a copy thereof to the operator or the representative of the miners, as appropriate. Any such hearing shall be of record and shall be subject to section 554 of title 5 of the United States Code.

80 Stat. 384.

(d) In any case where the provisions of sections 302 to 318, inclusive, of this title provide that certain actions, conditions, or requirements shall be carried out as prescribed by the Secretary, or the Secretary of Health, Education, and Welfare, as appropriate, the provisions of section 553 of title 5 of the United States Code shall apply unless either Secretary otherwise provides. Before granting any exception to a mandatory safety standard as authorized by this title, the findings of the Secretary or his authorized representative shall be made public and shall be available to the representative of the miners at the affected coal mine.

ROOF SUPPORT

SEC. 302. (a) Each operator shall undertake to carry out on a continuing basis a program to improve the roof control system of each coal mine and the means and measures to accomplish such system. The roof and ribs of all active underground roadways, travelways, and working places shall be supported or otherwise controlled adequately to protect persons from falls of the roof or ribs. A roof control plan and revisions thereof suitable to the roof conditions and mining system of each coal mine and approved by the Secretary shall be adopted and set out in printed form within sixty days after the operative date of this title. The plan shall show the type of support and spacing approved by the Secretary. Such plan shall be reviewed periodically, at least every six months by the Secretary, taking into consideration any falls of roof or ribs or inadequacy of support of roof or ribs. No person shall proceed beyond the last permanent sup-

port unless adequate temporary support is provided or unless such temporary support is not required under the approved roof control plan and the absence of such support will not pose a hazard to the miners. A copy of the plan shall be furnished the Secretary or his authorized representative and shall be available to the miners and their representatives.

(b) The method of mining followed in any coal mine shall not expose the miner to unusual dangers from roof falls caused by excessive widths of rooms and entries or faulty pillar recovery methods.

(c) The operator, in accordance with the approved plan, shall provide at or near each working face and at such other locations in the coal mine as the Secretary may prescribe an ample supply of suitable materials of proper size with which to secure the roof of all working places in a safe manner. Safety posts, jacks, or other approved devices shall be used to protect the workmen when roof material is being taken down, crossbars are being installed, roof boltholes are being drilled, roof bolts are being installed, and in such other circumstances as may be appropriate. Loose roof and overhanging or loose faces and ribs shall be taken down or supported. Except in the case of recovery work, supports knocked out shall be replaced promptly.

(d) When installation of roof bolts is permitted, such roof bolts shall be tested in accordance with the approved roof control plan.

(e) Roof bolts shall not be recovered where complete extractions of pillars are attempted, where adjacent to clay veins, or at the locations of other irregularities, whether natural or otherwise, that induce abnormal hazards. Where roof bolt recovery is permitted, it shall be conducted only in accordance with methods prescribed in the approved roof control plan, and shall be conducted by experienced miners and only where adequate temporary support is provided.

(f) Where miners are exposed to danger from falls of roof, face, and ribs the operator shall examine and test the roof, face, and ribs before any work or machine is started, and as frequently thereafter as may be necessary to insure safety. When dangerous conditions are found, they shall be corrected immediately.

VENTILATION

SEC. 303. (a) All coal mines shall be ventilated by mechanical ventilation equipment installed and operated in a manner approved by an authorized representative of the Secretary and such equipment shall be examined daily and a record shall be kept of such examination.

(b) All active workings shall be ventilated by a current of air containing not less than 19.5 volume per centum of oxygen, not more than 0.5 volume per centum of carbon dioxide, and no harmful quantities of other noxious or poisonous gases; and the volume and velocity of the current of air shall be sufficient to dilute, render harmless, and to carry away, flammable, explosive, noxious, and harmful gases, and dust, and smoke and explosive fumes. The minimum quantity of air reaching the last open crosscut in any pair or set of developing entries and the last open crosscut in any pair or set of rooms shall be nine thousand cubic feet a minute, and the minimum quantity of air reaching the intake end of a pillar line shall be nine thousand cubic feet a minute. The minimum quantity of air in any coal mine reaching each working face shall be three thousand cubic feet a minute. Within three months after the operative date of this title, the Secretary shall prescribe the minimum velocity and quantity of air reaching each working face of each coal mine in order to render harmless and carry away methane and

other explosive gases and to reduce the level of respirable dust to the lowest attainable level. The authorized representative of the Secretary may require in any coal mine a greater quantity and velocity of air when he finds it necessary to protect the health or safety of miners. Within one year after the operative date of this title, the Secretary or his authorized representative shall prescribe the maximum respirable dust level in the intake aircourses in each coal mine in order to reduce such level to the lowest attainable level. In robbing areas of anthracite mines, where the air currents cannot be controlled and measurements of the air cannot be obtained, the air shall have perceptible movement.

(c) (1) Properly installed and adequately maintained line brattice or other approved devices shall be continuously used from the last open crosscut of an entry or room of each working section to provide adequate ventilation to the working faces for the miners and to remove flammable, explosive, and noxious gases, dust, and explosive fumes, unless the Secretary or his authorized representative permits an exception to this requirement, where such exception will not pose a hazard to the miners. When damaged by falls or otherwise, such line brattice or other devices shall be repaired immediately.

(2) The space between the line brattice or other approved device and the rib shall be large enough to permit the flow of a sufficient volume and velocity of air to keep the working face clear of flammable, explosive, and noxious gases, dust, and explosive fumes.

(3) Brattice cloth used underground shall be of flame-resistant material.

Pre-shift
examinations.

(d) (1) Within three hours immediately preceding the beginning of any shift, and before any miner in such shift enters the active workings of a coal mine, certified persons designated by the operator of the mine shall examine such workings and any other underground area of the mine designated by the Secretary or his authorized representative. Each such examiner shall examine every working section in such workings and shall make tests in each such working section for accumulations of methane with means approved by the Secretary for detecting methane and shall make tests for oxygen deficiency with a permissible flame safety lamp or other means approved by the Secretary; examine seals and doors to determine whether they are functioning properly; examine and test the roof, face, and rib conditions in such working section; examine active roadways, travelways, and belt conveyors on which men are carried, approaches to abandoned areas, and accessible falls in such section for hazards; test by means of an anemometer or other device approved by the Secretary to determine whether the air in each split is traveling in its proper course and in normal volume and velocity; and examine for such other hazards and violations of the mandatory health or safety standards, as an authorized representative of the Secretary may from time to time require. Belt conveyors on which coal is carried shall be examined after each coal-producing shift has begun. Such mine examiner shall place his initials and the date and time at all places he examines. If such mine examiner finds a condition which constitutes a violation of a mandatory health or safety standard or any condition which is hazardous to persons who may enter or be in such area, he shall indicate such hazardous place by posting a "DANGER" sign conspicuously at all points which persons entering such hazardous place would be required to pass, and shall notify the operator of the mine. No person, other than an authorized representative of the Secretary or a State mine inspector or persons authorized by the operator to enter such place

for the purpose of eliminating the hazardous condition therein, shall enter such place while such sign is so posted. Upon completing his examination, such mine examiner shall report the results of his examination to a person, designated by the operator to receive such reports at a designated station on the surface of the mine, before other persons enter the underground areas of such mine to work in such shift. Each such mine examiner shall also record the results of his examination with ink or indelible pencil in a book approved by the Secretary kept for such purpose in an area on the surface of the mine chosen by the operator to minimize the danger of destruction by fire or other hazard, and the record shall be open for inspection by interested persons.

Records.

(2) No person (other than certified persons designated under this subsection) shall enter any underground area, except during any shift, unless an examination of such area as prescribed in this subsection has been made within eight hours immediately preceding his entrance into such area.

(e) At least once during each coal-producing shift, or more often if necessary for safety, each working section shall be examined for hazardous conditions by certified persons designated by the operator to do so. Any such condition shall be corrected immediately. If such condition creates an imminent danger, the operator shall withdraw all persons from the area affected by such condition to a safe area, except those persons referred to in section 104(d) of this Act, until the danger is abated. Such examination shall include tests for methane with a means approved by the Secretary for detecting methane and for oxygen deficiency with a permissible flame safety lamp or other means approved by the Secretary.

Ante, p. 751.

(f) In addition to the pre-shift and daily examinations required by this section, examinations for hazardous conditions, including tests for methane, and for compliance with the mandatory health or safety standards, shall be made at least once each week by a certified person designated by the operator in the return of each split of air where it enters the main return, on pillar falls, at seals, in the main return, at least one entry of each intake and return aircourse in its entirety, idle workings, and, insofar as safety considerations permit, abandoned areas. Such weekly examination need not be made during any week in which the mine is idle for the entire week, except that such examination shall be made before any other miner returns to the mine. The person making such examinations and tests shall place his initials and the date and time at the places examined, and if any hazardous condition is found, such condition shall be reported to the operator promptly. Any hazardous condition shall be corrected immediately. If such condition creates an imminent danger, the operator shall withdraw all persons from the area affected by such condition to a safe area, except those persons referred to in section 104(d) of this Act, until such danger is abated. A record of these examinations, tests, and actions taken shall be recorded in ink or indelible pencil in a book approved by the Secretary kept for such purpose in an area on the surface of the mine chosen by the mine operator to minimize the danger of destruction by fire or other hazard, and the record shall be open for inspection by interested persons.

Weekly
examinations
for hazardous
conditions.

Records.

(g) At least once each week, a qualified person shall measure the volume of air entering the main intakes and leaving the main returns, the volume passing through the last open crosscut in any pair or set of developing entries and the last open crosscut in any pair or set of

Weekly
ventilation
examinations.

Records.

Methane
examinations.

rooms, the volume and, when the Secretary so prescribes, the velocity reaching each working face, the volume being delivered to the intake end of each pillar line, and the volume at the intake and return of each split of air. A record of such measurements shall be recorded in ink or indelible pencil in a book approved by the Secretary kept for such purpose in an area on the surface of the coal mine chosen by the operator to minimize the danger of destruction by fire or other hazard, and the record shall be open for inspection by interested persons.

(k) (1) At the start of each shift, tests for methane shall be made at each working place immediately before electrically operated equipment is energized. Such tests shall be made by qualified persons. If 1.0 volume per centum or more of methane is detected, electrical equipment shall not be energized, taken into, or operated in, such working place until the air therein contains less than 1.0 volume per centum of methane. Examinations for methane shall be made during the operation of such equipment at intervals of not more than twenty minutes during each shift, unless more frequent examinations are required by an authorized representative of the Secretary. In conducting such tests, such person shall use means approved by the Secretary for detecting methane.

(2) If at any time the air at any working place, when tested at a point not less than twelve inches from the roof, face, or rib, contains 1.0 volume per centum or more of methane, changes or adjustments shall be made at once in the ventilation in such mine so that such air shall contain less than 1.0 volume per centum of methane. While such changes or adjustments are underway and until they have been achieved, power to electric face equipment located in such place shall be cut off, no other work shall be permitted in such place, and due precautions shall be carried out under the direction of the operator or his agent so as not to endanger other areas of the mine. If at any time such air contains 1.5 volume per centum or more of methane, all persons, except those referred to in section 104(d) of this Act, shall be withdrawn from the area of the mine endangered thereby to a safe area, and all electric power shall be cut off from the endangered area of the mine, until the air in such working place shall contain less than 1.0 volume per centum of methane.

Ante, p. 751.

(i) (1) If, when tested, a split of air returning from any working section contains 1.0 volume per centum or more of methane, changes or adjustments shall be made at once in the ventilation in the mine so that such returning air shall contain less than 1.0 volume per centum of methane. Tests under this paragraph and paragraph (2) of this subsection shall be made at four-hour intervals during each shift by a qualified person designated by the operator of the mine. In making such tests, such person shall use means approved by the Secretary for detecting methane.

(2) If, when tested, a split of air returning from any working section contains 1.5 volume per centum or more of methane, all persons, except those persons referred to in section 104(d) of this Act, shall be withdrawn from the area of the mine endangered thereby to a safe area and all electric power shall be cut off from the endangered area of the mine, until the air in such split shall contain less than 1.0 volume per centum of methane.

(3) In virgin territory, if the quantity of air in a split ventilating the active workings in such territory equals or exceeds twice the minimum volume of air prescribed in subsection (b) of this section for the last open crosscut, if the air in the split returning from such workings

does not pass over trolley wires or trolley feeder wires, and if a certified person designated by the operator is continually testing the methane content of the air in such split during mining operations in such workings, it shall be necessary to withdraw all persons, except those referred to in section 104(d) of this Act, from the area of the mine endangered thereby to a safe area and all electric power shall be cut off from the endangered area only when the air returning from such workings contains 2.0 volume per centum or more of methane.

Ante, p. 751.

(j) Air which has passed by an opening of any abandoned area shall not be used to ventilate any working place in the coal mine if such air contains 0.25 volume per centum or more of methane. Examinations of such air shall be made during the pre-shift examination required by subsection (d) of this section. In making such tests, a certified person designated by the operator shall use means approved by the Secretary for detecting methane. For the purposes of this subsection, an area within a panel shall not be deemed to be abandoned until such panel is abandoned.

(k) Air that has passed through an abandoned area or an area which is inaccessible or unsafe for inspection shall not be used to ventilate any working place in any mine. No air which has been used to ventilate an area from which the pillars have been removed shall be used to ventilate any working place in a mine, except that such air, if it does not contain 0.25 volume per centum or more of methane, may be used to ventilate enough advancing working places immediately adjacent to the line of retreat to maintain an orderly sequence of pillar recovery on a set of entries.

(l) The Secretary or his authorized representative shall require, as an additional device for detecting concentrations of methane, that a methane monitor, approved as reliable by the Secretary after the operative date of this title, be installed, when available, on any electric face cutting equipment, continuous miner, longwall face equipment, and loading machine, except that no monitor shall be required to be installed on any such equipment prior to the date on which such equipment is required to be permissible under section 305(a) of this title. When installed on any such equipment, such monitor shall be kept operative and properly maintained and frequently tested as prescribed by the Secretary. The sensing device of such monitor shall be installed as close to the working face as practicable. Such monitor shall be set to deenergize automatically such equipment when such monitor is not operating properly and to give a warning automatically when the concentration of methane reaches a maximum percentage determined by an authorized representative of the Secretary which shall not be more than 1.0 volume per centum of methane. An authorized representative of the Secretary shall require such monitor to deenergize automatically equipment on which it is installed when the concentration of methane reaches a maximum percentage determined by such representative which shall not be more than 2.0 volume per centum of methane.

Methane
monitor.

Post, p. 775.

(m) Idle and abandoned areas shall be inspected for methane and for oxygen deficiency and other dangerous conditions by a certified person with means approved by the Secretary as soon as possible but not more than three hours before other persons are permitted to enter or work in such areas. Persons, such as pumpmen, who are required regularly to enter such areas in the performance of their duties, and who are trained and qualified in the use of means approved by the

Secretary for detecting methane and in the use of a permissible flame safety lamp or other means approved by the Secretary for detecting oxygen deficiency are authorized to make such examinations for themselves, and each such person shall be properly equipped and shall make such examinations upon entering any such area.

(n) Immediately before an intentional roof fall is made, pillar workings shall be examined by a qualified person designated by the operator to ascertain whether methane is present. Such person shall use means approved by the Secretary for detecting methane. If in such examination methane is found in amounts of 1.0 volume per centum or more, such roof fall shall not be made until changes or adjustments are made in the ventilation so that the air shall contain less than 1.0 volume per centum of methane.

(o) A ventilation system and methane and dust control plan and revisions thereof suitable to the conditions and the mining system of the coal mine and approved by the Secretary shall be adopted by the operator and set out in printed form within ninety days after the operative date of this title. The plan shall show the type and location of mechanical ventilation equipment installed and operated in the mine, such additional or improved equipment as the Secretary may require, the quantity and velocity of air reaching each working face, and such other information as the Secretary may require. Such plan shall be reviewed by the operator and the Secretary at least every six months.

(p) Each operator shall provide for the proper maintenance and care of the permissible flame safety lamp or any other approved device for detecting methane and oxygen deficiency by a person trained in such maintenance, and, before each shift, care shall be taken to insure that such lamp or other device is in a permissible condition.

(q) Where areas are being pillared on the operative date of this title without bleeder entries, or without bleeder systems or an equivalent means, pillar recovery may be completed in the area, to the extent approved by an authorized representative of the Secretary, if the edges of pillar lines adjacent to active workings are ventilated with sufficient air to keep the air in open areas along the pillar lines below 1.0 volume per centum of methane.

(r) Each mechanized mining section shall be ventilated with a separate split of intake air directed by overcasts, undercasts, or the equivalent, except an extension of time, not in excess of nine months, may be permitted by the Secretary, under such conditions as he may prescribe, whenever he determines that this subsection cannot be complied with on the operative date of this title.

(s) In all underground areas of a coal mine, immediately before firing each shot or group of multiple shots and after blasting is completed, examinations for methane shall be made by a qualified person with means approved by the Secretary for detecting methane. If methane is found in amounts of 1.0 volume per centum or more, changes or adjustments shall be made at once in the ventilation so that the air shall contain less than 1.0 volume per centum of methane. No shots shall be fired until the air contains less than 1.0 volume per centum of methane.

(t) Each operator shall adopt a plan within sixty days after the operative date of this title which shall provide that when any mine fan stops, immediate action shall be taken by the operator or his agent (1) to withdraw all persons from the working sections, (2) to cut off the power in the mine in a timely manner, (3) to provide for restora-

tion of power and resumption of work if ventilation is restored within a reasonable period as set forth in the plan after the working places and other active workings where methane is likely to accumulate are reexamined by a certified person to determine if methane in amounts of 1.0 volume per centum or more exists therein, and (4) to provide for withdrawal of all persons from the mine if ventilation cannot be restored within such reasonable time. The plan and revisions thereof approved by the Secretary shall be set out in printed form and a copy shall be furnished to the Secretary or his authorized representative.

(u) Changes in ventilation which materially affect the main air current or any split thereof and which may affect the safety of persons in the coal mine shall be made only when the mine is idle. Only those persons engaged in making such changes shall be permitted in the mine during the change. Power shall be removed from the areas affected by the change before work starts to make the change and shall not be restored until the effect of the change has been ascertained and the affected areas determined to be safe by a certified person.

(v) The mine foreman shall read and countersign promptly the daily reports of the pre-shift examiner and assistant mine foremen, and he shall read and countersign promptly the weekly report covering the examinations for hazardous conditions. Where such reports disclose hazardous conditions, they shall be corrected promptly. If such conditions create an imminent danger, the operator shall withdraw all persons from, or prevent any person from entering, as the case may be, the area affected by such conditions, except those persons referred to in section 104(d) of this Act, until such danger is abated. The mine superintendent or assistant superintendent of the mine shall also read and countersign the daily and weekly reports of such persons.

Reports.

Ante, p. 751.

(w) Each day, the mine foreman and each of his assistants shall enter plainly and sign with ink or indelible pencil in a book approved by the Secretary provided for that purpose a report of the condition of the mine or portion thereof under his supervision, which report shall state clearly the location and nature of any hazardous condition observed by him or reported to him during the day and what action was taken to remedy such condition. Such book shall be kept in an area on the surface of the mine chosen by the operator to minimize the danger of destruction by fire or other hazard, and shall be open for inspection by interested persons.

Daily reports.

(x) Before a coal mine is reopened after having been abandoned or declared inactive by the operator, the Secretary shall be notified, and an inspection shall be made of the entire mine by an authorized representative of the Secretary before mining operations commence.

(y) (1) In any coal mine opened after the operative date of this title, the entries used as intake and return aircourses shall be separated from belt haulage entries, and each operator of such mine shall limit the velocity of the air coursed through belt haulage entries to the amount necessary to provide an adequate supply of oxygen in such entries, and to insure that the air therein shall contain less than 1.0 volume per centum of methane, and such air shall not be used to ventilate active working places. Whenever an authorized representative of the Secretary finds, in the case of any coal mine opened on or prior to the operative date of this title which has been developed with more than two entries, that the conditions in the entries, other than belt haulage entries, are such as to permit adequately the coursing of intake or return air through such entries, (1) the belt haulage entries shall not be used to ventilate, unless such entries are necessary to ventilate, active working places, and (2) when the belt haulage entries are not

necessary to ventilate the active working places, the operator of such mine shall limit the velocity of the air coursed through the belt haulage entries to the amount necessary to provide an adequate supply of oxygen in such entries, and to insure that the air therein shall contain less than 1.0 volume per centum of methane.

(2) In any coal mine opened on or after the operative date of this title, or, in the case of a coal mine opened prior to such date, in any new working section of such mine, where trolley haulage systems are maintained and where trolley wires or trolley feeder wires are installed, an authorized representative of the Secretary shall require a sufficient number of entries or rooms as intake aircourses in order to limit, as prescribed by the Secretary, the velocity of air currents on such haulageways for the purpose of minimizing the hazards associated with fires and dust explosions in such haulageways.

(z) (1) While pillars are being extracted in any area of a coal mine, such area shall be ventilated in the manner prescribed by this section.

(2) Within nine months after the operative date of this title, all areas from which pillars have been wholly or partially extracted and abandoned areas, as determined by the Secretary or his authorized representative, shall be ventilated by bleeder entries or by bleeder systems or equivalent means, or be sealed, as determined by the Secretary or his authorized representative. When ventilation of such areas is required, such ventilation shall be maintained so as continuously to dilute, render harmless, and carry away methane and other explosive gases within such areas and to protect the active workings of the mine from the hazards of such methane and other explosive gases. Air coursed through underground areas from which pillars have been wholly or partially extracted which enters another split of air shall not contain more than 2.0 volume per centum of methane, when tested at the point it enters such other split. When sealing is required, such seals shall be made in an approved manner so as to isolate with explosion-proof bulkheads such areas from the active workings of the mine.

(3) In the case of mines opened on or after the operative date of this title, or in the case of working sections opened on or after such date in mines opened prior to such date, the mining system shall be designed in accordance with a plan and revisions thereof approved by the Secretary and adopted by such operator so that, as each working section of the mine is abandoned, it can be isolated from the active workings of the mine with explosion-proof seals or bulkheads.

COMBUSTIBLE MATERIALS AND ROCK DUSTING

SEC. 304. (a) Coal dust, including float coal dust deposited on rock-dusted surfaces, loose coal, and other combustible materials, shall be cleaned up and not be permitted to accumulate in active workings, or on electric equipment therein.

(b) Where underground mining operations in active workings create or raise excessive amounts of dust, water or water with a wetting agent added to it, or other no less effective methods approved by the Secretary or his authorized representative, shall be used to abate such dust. In working places, particularly in distances less than forty feet from the face, water, with or without a wetting agent, or other no less effective methods approved by the Secretary or his authorized representative, shall be applied to coal dust on the ribs, roof, and floor to reduce dispersibility and to minimize the explosion hazard.

(c) All underground areas of a coal mine, except those areas in which the dust is too wet or too high in incombustible content to propagate an explosion, shall be rock dusted to within forty feet of all working faces, unless such areas are inaccessible or unsafe to enter or unless the Secretary or his authorized representative permits an exception upon his finding that such exception will not pose a hazard to the miners. All crosscuts that are less than forty feet from a working face shall also be rock dusted.

(d) Where rock dust is required to be applied, it shall be distributed upon the top, floor, and sides of all underground areas of a coal mine and maintained in such quantities that the incombustible content of the combined coal dust, rock dust, and other dust shall be not less than 65 per centum, but the incombustible content in the return aircourses shall be no less than 80 per centum. Where methane is present in any ventilating current, the per centum of incombustible content of such combined dusts shall be increased 1.0 and 0.4 per centum for each 0.1 per centum of methane where 65 and 80 per centum, respectively, of incombustibles are required.

(e) Subsections (b) through (d) of this section shall not apply to underground anthracite mines.

Nonapplicability.

ELECTRICAL EQUIPMENT—GENERAL

SEC. 305. (a) (1) Effective one year after the operative date of this title—

(A) all junction or distribution boxes used for making multiple power connections in by the last open crosscut shall be permissible;

(B) all handheld electric drills, blower and exhaust fans, electric pumps, and such other low horsepower electric face equipment as the Secretary may designate within two months after the operative date of this title which are taken into or used in by the last open crosscut of any coal mine shall be permissible;

(C) all electric face equipment which is taken into or used in by the last open crosscut of any coal mine classified under any provision of law as gassy prior to the operative date of this title shall be permissible; and

(D) all other electric face equipment which is taken into or used in by the last crosscut of any coal mine, except a coal mine referred to in paragraph (2) of this subsection, which has not been classified under any provision of law as a gassy mine prior to the operative date of this title shall be permissible.

(2) Effective four years after the operative date of this title, all electric face equipment, other than equipment referred to in paragraph (1) (B) of this subsection, which is taken into or used in by the last open crosscut of any coal mine which is operated entirely in coal seams located above the watertable and which has not been classified under any provision of law as a gassy mine prior to the operative date of this title and in which one or more openings were made prior to the date of enactment of this Act, shall be permissible, except that any operator of such mine who is unable to comply with the provisions of this paragraph on such effective date may file with the Panel an application for a permit for noncompliance ninety days prior to such date. If the Panel determines, after notice to all interested persons and an opportunity for a public hearing under section 5 of this Act, that such application satisfies the provisions of paragraph (10) of this

Permit for noncompliance.

Ante, p. 744.

subsection and that such operator, despite his diligent efforts, will be unable to comply with such provisions, the Panel may issue to such operator such a permit. Such permit shall entitle the permittee to an additional extension of time to comply with the provisions of this paragraph of not to exceed twenty-four months, as determined by the Panel, from such effective date.

(3) The operator of each coal mine shall maintain in permissible condition all electric face equipment required by this subsection to be permissible which is taken into or used in by the last open crosscut of any such mine.

(4) Each operator of a coal mine shall, within two months after the operative date of this title, file with the Secretary a statement listing all electric face equipment by type and manufacturer being used by such operator in connection with mining operations in such mine as of the date of such filing, and stating whether such equipment is permissible and maintained in permissible condition or is nonpermissible on such date of filing, and, if nonpermissible, whether such nonpermissible equipment has ever been rated as permissible, and such other information as the Secretary may require.

(5) The Secretary shall promptly conduct a survey as to the total availability of new or rebuilt permissible electric face equipment and replacement parts for such equipment and, within six months after the operative date of this title, publish the results of such survey.

(6) Any operator of a coal mine who is unable to comply with the provisions of paragraph (1)(D) of this subsection within one year after the operative date of this title may file with the Panel an application for a permit for noncompliance. If the Panel determines that such application satisfies the provisions of paragraph (10) of this subsection, the Panel shall issue to such operator a permit for noncompliance. Such permit shall entitle the permittee to an extension of time to comply with such provisions of paragraph (1)(D) of not to exceed twelve months, as determined by the Panel, from the date that compliance with the provisions of paragraph (1)(D) of this subsection is required.

(7) Any operator of a coal mine issued a permit under paragraph (6) of this subsection who, ninety days prior to the termination of such permit, or renewal thereof, determines that he will be unable to comply with the provisions of paragraph (1)(D) of this subsection upon the expiration of such permit may file with the Panel an application for renewal thereof. Upon receipt of such application, the Panel, if it determines, after notice to all interested persons and an opportunity for a public hearing under section 5 of this Act, that such application satisfies the provisions of paragraph (10) of this subsection and that such operator, despite his diligent efforts, will be unable to comply with the provisions of paragraph (1)(D), may renew the permit for a period not exceeding twelve months.

(8) Any permit or renewal thereof issued pursuant to this subsection shall entitle the permittee to use such nonpermissible electric face equipment specified in the permit during the term of such permit.

(9) Permits for noncompliance issued under paragraphs (6) or (7) of this subsection shall, in the aggregate, not extend the period of noncompliance more than forty-eight months after the date of enactment of this Act.

(10) Any application for a permit of noncompliance filed under this subsection shall contain a statement by the operator—

Survey,
publication.

Permit for
noncompliance.

Permit
renewal.

Ante, p.744.

Permit
limitation.

Contents.

(A) that he is unable to comply with paragraph (1)(D) or paragraph (2) of this subsection, as appropriate, within the time prescribed;

(B) listing the nonpermissible electric face equipment being used by such operator in connection with mining operations in such mine on the operative date of this title and the date of the application by type and manufacturer for which a noncompliance permit is requested and whether such equipment had ever been rated as permissible;

(C) setting forth the actions taken from and after the operative date of this title to comply with paragraph (1)(D) or paragraph (2) of this subsection, as appropriate, together with a plan setting forth a schedule of compliance with said paragraphs for each such equipment referred to in such paragraphs and being used by the operator in connection with mining operations in such mine with respect to which such permit is requested and the means and measures to be employed to achieve compliance; and

(D) including such other information as the Panel may require.

(11) No permit for noncompliance shall be issued under this subsection for any nonpermissible electric face equipment, unless such equipment was being used by an operator in connection with the mining operations in a coal mine on the operative date of this title.

(12) Effective one year after the operative date of this title, all replacement equipment acquired for use in any mine referred to in this subsection shall be permissible and shall be maintained in a permissible condition, and in the event of any major overhaul of any item of equipment in use one year from the operative date of this title such equipment shall be put in, and thereafter maintained in, a permissible condition, unless, in the opinion of the Secretary, such equipment or necessary replacement parts are not available.

(b) A copy of any permit granted under this section shall be mailed immediately to a representative of the miners of the mine to which it pertains, and to the public official or agency of the State charged with administering State laws relating to coal mine health and safety in such mine.

(c) Any coal mine which, prior to the operative date of this title, was classed gassy under any provision of law and was required to use permissible electric face equipment and to maintain such equipment in a permissible condition shall continue to use such equipment and to maintain such equipment in such condition.

(d) All power-connection points, except where permissible power connection units are used, outby the last open crosscut shall be in intake air.

(e) The location and the electrical rating of all stationary electric apparatus in connection with the mine electric system, including permanent cables, switchgear, rectifying substations, transformers, permanent pumps and trolley wires and trolley feeder wires, and settings of all direct-current circuit breakers protecting underground trolley circuits, shall be shown on a mine map. Any changes made in a location, electric rating, or setting shall be promptly shown on the map when the change is made. Such map shall be available to an authorized representative of the Secretary and to the miners in such mine.

Mine map.

(f) All power circuits and electric equipment shall be deenergized before work is done on such circuits and equipment, except when

necessary for trouble shooting or testing. In addition, energized trolley wires may be repaired only by a person trained to perform electrical work and to maintain electrical equipment and the operator of such mine shall require that such person wear approved and tested insulated shoes and wireman's gloves. No electrical work shall be performed on low-, medium-, or high-voltage distribution circuits or equipment, except by a qualified person or by a person trained to perform electrical work and to maintain electrical equipment under the direct supervision of a qualified person. Disconnecting devices shall be locked out and suitably tagged by the persons who performed such work, except that, in cases where locking out is not possible, such devices shall be opened and suitably tagged by such persons. Locks or tags shall be removed only by the persons who installed them or, if such persons are unavailable, by persons authorized by the operator or his agent.

Examinations.

(g) All electric equipment shall be frequently examined, tested, and properly maintained by a qualified person to assure safe operating conditions. When a potentially dangerous condition is found on electric equipment, such equipment shall be removed from service until such condition is corrected. A record of such examinations shall be kept and made available to an authorized representative of the Secretary and to the miners in such mine.

Records.

(h) All electric conductors shall be sufficient in size and have adequate current-carrying capacity and be of such construction that a rise in temperature resulting from normal operation will not damage the insulating materials.

(i) All electrical connections or splices in conductors shall be mechanically and electrically efficient, and suitable connectors shall be used. All electrical connections or splices in insulated wire shall be reinsulated at least to the same degree of protection as the remainder of the wire.

(j) Cables shall enter metal frames of motors, splice boxes, and electric compartments only through proper fittings. When insulated wires other than cables pass through metal frames the holes shall be substantially bushed with insulated bushings.

(k) All power wires (except trailing cables on mobile equipment, specially designed cables conducting high-voltage power to underground rectifying equipment or transformers, or bare or insulated ground and return wires) shall be supported on well-insulated insulators and shall not contact combustible material, roof, or ribs.

(l) Power wires and cables, except trolley wires, trolley feeder wires, and bare signal wires, shall be insulated adequately and fully protected.

(m) Automatic circuit-breaking devices or fuses of the correct type and capacity shall be installed so as to protect all electric equipment and circuits against short circuit and overloads. Three-phase motors on all electric equipment shall be provided with overload protection that will deenergize all three phases in the event that any phase is overloaded.

(n) In all main power circuits, disconnecting switches shall be installed underground within five hundred feet of the bottoms of shafts and boreholes through which main power circuits enter the underground area of the mine and within five hundred feet of all other places where main power circuits enter the underground area of the mine.

(o) All electric equipment shall be provided with switches or other controls that are safely designed, constructed, and installed.

(p) Each ungrounded, exposed power conductor that leads underground shall be equipped with suitable lightning arresters of approved type within one hundred feet of the point where the circuit enters the mine. Lightning arresters shall be connected to a low resistance grounding medium on the surface which shall be separated from neutral grounds by a distance of not less than twenty-five feet.

(q) No device for the purpose of lighting any coal mine which has not been approved by the Secretary or his authorized representative shall be permitted in such mine.

(r) An authorized representative of the Secretary may require in any mine that electric face equipment be provided with devices that will permit the equipment to be deenergized quickly in the event of an emergency.

TRAILING CABLES

SEC. 306. (a) Trailing cables used in coal mines shall meet the requirements established by the Secretary for flame-resistant cables.

(b) Short-circuit protection for trailing cables shall be provided by an automatic circuit breaker or other no less effective device approved by the Secretary of adequate current-interrupting capacity in each ungrounded conductor. Disconnecting devices used to disconnect power from trailing cables shall be plainly marked and identified and such devices shall be equipped or designed in such a manner that it can be determined by visual observation that the power is disconnected.

(c) When two or more trailing cables junction to the same distribution center, means shall be provided to assure against connecting a trailing cable to the wrong size circuit breaker.

(d) One temporary splice may be made in any trailing cable. Such trailing cable may only be used for the next twenty-four hour period. No temporary splice shall be made in a trailing cable within twenty-five feet of the machine, except cable reel equipment. Temporary splices in trailing cables shall be made in a workmanlike manner and shall be mechanically strong and well insulated. Trailing cables or hand cables which have exposed wires or which have splices that heat or spark under load shall not be used. As used in this subsection, the term "splice" means the mechanical joining of one or more conductors that have been severed.

"Splice."

(e) When permanent splices in trailing cables are made, they shall be—

(1) mechanically strong with adequate electrical conductivity and flexibility;

(2) effectively insulated and sealed so as to exclude moisture; and

(3) vulcanized or otherwise treated with suitable materials to provide flame-resistant qualities and good bonding to the outer jacket.

(f) Trailing cables shall be clamped to machines in a manner to protect the cables from damage and to prevent strain on the electrical connections. Trailing cables shall be adequately protected to prevent damage by mobile equipment.

(g) Trailing cable and power cable connections to junction boxes shall not be made or broken under load.

GROUNDING

SEC. 307. (a) All metallic sheaths, armors, and conduits enclosing power conductors shall be electrically continuous throughout and shall be grounded by methods approved by an authorized representative of the Secretary. Metallic frames, casings, and other enclosures of electric equipment that can become "alive" through failure of insulation or by contact with energized parts shall be grounded by methods approved by an authorized representative of the Secretary. Methods other than grounding which provide no less effective protection may be permitted by the Secretary or his authorized representative.

(b) The frames of all offtrack direct current machines and the enclosures of related detached components shall be effectively grounded, or otherwise maintained at no less safe voltages, by methods approved by an authorized representative of the Secretary.

(c) The frames of all stationary high-voltage equipment receiving power from ungrounded delta systems shall be grounded by methods approved by an authorized representative of the Secretary.

(d) High-voltage lines, both on the surface and underground, shall be deenergized and grounded before work is performed on them, except that repairs may be permitted, in the case of energized surface high-voltage lines, if such repairs are made by a qualified person in accordance with procedures and safeguards, including, but not limited to, a requirement that the operator of such mine provide, test, and maintain protective devices in making such repairs, to be prescribed by the Secretary prior to the operative date of this title.

(e) When not in use, power circuits underground shall be deenergized on idle days and idle shifts, except that rectifiers and transformers may remain energized.

UNDERGROUND HIGH-VOLTAGE DISTRIBUTION

SEC. 308. (a) High-voltage circuits entering the underground area of any coal mine shall be protected by suitable circuit breakers of adequate interrupting capacity which are properly tested and maintained as prescribed by the Secretary. Such breakers shall be equipped with devices to provide protection against under-voltage, grounded phase, short circuit, and overcurrent.

(b) High-voltage circuits extending underground and supplying portable, mobile, or stationary high-voltage equipment shall contain either a direct or derived neutral which shall be grounded through a suitable resistor at the source transformers, and a grounding circuit, originating at the grounded side of the grounding resistor, shall extend along with the power conductors and serve as a grounding conductor for the frames of all high-voltage equipment supplied power from that circuit, except that the Secretary or his authorized representative may permit ungrounded high-voltage circuits to be extended underground to feed stationary electrical equipment if such circuits are either steel armored or installed in grounded, rigid steel conduit throughout their entire length, and upon his finding that such exception does not pose a hazard to the miners. Within one hundred feet of the point on the surface where high-voltage circuits enter the underground portion of the mine, disconnecting devices shall be installed and so equipped or designed in such a manner that it can be determined by visual observation that the power is disconnected, except that the Secretary or his authorized representative may permit such devices to be installed at a greater distance from such area of the mine if he

determines, based on existing physical conditions, that such installation will be more accessible at a greater distance and will not pose any hazard to the miners.

(c) The grounding resistor, where required, shall be of the proper ohmic value to limit the voltage drop in the grounding circuit external to the resistor to not more than 100 volts under fault conditions. The grounding resistor shall be rated for maximum fault current continuously and insulated from ground for a voltage equal to the phase-to-phase voltage of the system.

(d) Six months after the operative date of this title, high-voltage, resistance grounded systems shall include a fail safe ground check circuit to monitor continuously the grounding circuit to assure continuity and the fail safe ground check circuit shall cause the circuit breaker to open when either the ground or pilot check wire is broken, or other no less effective device approved by the Secretary or his authorized representative to assure such continuity, except that an extension of time, not in excess of twelve months, may be permitted by the Secretary on a mine-by-mine basis if he determines that such equipment is not available.

(e) (1) Underground high-voltage cables used in resistance grounded systems shall be equipped with metallic shields around each power conductor, with one or more ground conductors having a total cross-sectional area of not less than one-half the power conductor, and with an insulated internal or external conductor not smaller than No. 8 (AWG) for the ground continuity check circuit.

(2) All such cables shall be adequate for the intended current and voltage. Splices made in such cables shall provide continuity of all components.

(f) Couplers that are used with medium-voltage or high-voltage power circuits shall be of the three-phase type with a full metallic shell, except that the Secretary may permit, under such guidelines as he may prescribe, no less effective couplers constructed of materials other than metal. Couplers shall be adequate for the voltage and current expected. All exposed metal on the metallic couplers shall be grounded to the ground conductor in the cable. The coupler shall be constructed so that the ground check continuity conductor shall be broken first and the ground conductors shall be broken last when the coupler is being uncoupled.

(g) Single-phase loads, such as transformer primaries, shall be connected phase to phase.

(h) All underground high-voltage transmission cables shall be installed only in regularly inspected aircourses and haulageways, and shall be covered, buried, or placed so as to afford protection against damage, guarded where men regularly work or pass under them unless they are six and one-half feet or more above the floor or rail, securely anchored, properly insulated, and guarded at ends, and covered, insulated, or placed to prevent contact with trolley wires and other low-voltage circuits.

(i) Disconnecting devices shall be installed at the beginning of branch lines in high-voltage circuits and equipped or designed in such a manner that it can be determined by visual observation that the circuit is deenergized when the switches are open.

(j) Circuit breakers and disconnecting switches underground shall be marked for identification.

(k) In the case of high-voltage cables used as trailing cables, temporary splices shall not be used and all permanent splices shall be

made in accordance with section 306(e) of this title. Terminations and splices in all other high-voltage cables shall be made in accordance with the manufacturer's specifications.

(l) Frames, supporting structures, and enclosures of stationary, portable, or mobile underground high-voltage equipment and all high-voltage equipment supplying power to such equipment receiving power from resistance grounded systems shall be effectively grounded to the high-voltage ground.

(m) Power centers and portable transformers shall be deenergized before they are moved from one location to another, except that, when equipment powered by sources other than such centers or transformers is not available, the Secretary may permit such centers and transformers to be moved while energized, if he determines that another equivalent or greater hazard may otherwise be created, and if they are moved under the supervision of a qualified person, and if such centers and transformers are examined prior to such movement by such person and found to be grounded by methods approved by an authorized representative of the Secretary and otherwise protected from hazards to the miner. A record shall be kept of such examinations. High-voltage cables, other than trailing cables, shall not be moved or handled at any time while energized, except that, when such centers and transformers are moved while energized as permitted under this subsection, energized high-voltage cables attached to such centers and transformers may be moved only by a qualified person and the operator of such mine shall require that such person wear approved and tested insulated wireman's gloves.

Records.

UNDERGROUND LOW- AND MEDIUM-VOLTAGE ALTERNATING CURRENT CIRCUITS

SEC. 309. (a) Low- and medium-voltage power circuits serving three-phase alternating current equipment shall be protected by suitable circuit breakers of adequate interrupting capacity which are properly tested and maintained as prescribed by the Secretary. Such breakers shall be equipped with devices to provide protection against under-voltage, grounded phase, short circuit, and over-current.

(b) Low- and medium-voltage three-phase alternating-current circuits used underground shall contain either a direct or derived neutral which shall be grounded through a suitable resistor at the power center, and a grounding circuit, originating at the grounded side of the grounding resistor, shall extend along with the power conductors and serve as a grounding conductor for the frames of all the electrical equipment supplied power from that circuit, except that the Secretary or his authorized representative may permit ungrounded low- and medium-voltage circuits to be used underground to feed such stationary electrical equipment if such circuits are either steel armored or installed in grounded rigid steel conduit throughout their entire length. The grounding resistor, where required, shall be of the proper ohmic value to limit the ground fault current to 25 amperes. The grounding resistor shall be rated for maximum fault current continuously and insulated from ground for a voltage equal to the phase-to-phase voltage of the system.

(c) Six months after the operative date of this title, low- and medium-voltage resistance grounded systems shall include a fail safe ground check circuit to monitor continuously the grounding circuit to assure continuity which ground check circuit shall cause the circuit

breaker to open when either the ground or pilot check wire is broken, or other no less effective device approved by the Secretary or his authorized representative to assure such continuity, except that an extension of time, not in excess of twelve months, may be permitted by the Secretary on a mine-by-mine basis if he determines that such equipment is not available. Cable couplers shall be constructed so that the ground check continuity conductor shall be broken first and the ground conductors shall be broken last when the coupler is being uncoupled.

(d) Disconnecting devices shall be installed in conjunction with the circuit breaker to provide visual evidence that the power is disconnected. Trailing cables for mobile equipment shall contain one or more ground conductors having a cross sectional area of not less than one-half the power conductor, and, six months after the operative date of this title, an insulated conductor for the ground continuity check circuit or other no less effective device approved by the Secretary or his authorized representative to assure such continuity, except that an extension of time, not in excess of twelve months may be permitted by the Secretary on a mine-by-mine basis if he determines that such equipment is not available. Splices made in the cables shall provide continuity of all components.

(e) Single phase loads shall be connected phase to phase.

(f) Circuit breakers shall be marked for identification.

(g) Trailing cables for medium voltage circuits shall include grounding conductors, a ground check conductor, and ground metallic shields around each power conductor or a grounded metallic shield over the assembly, except that on equipment employing cable reels, cables without shields may be used if the insulation is rated 2,000 volts or more.

TROLLEY WIRES AND TROLLEY FEEDER WIRES

SEC. 310. (a) Trolley wires and trolley feeder wires shall be provided with cutout switches at intervals of not more than 2,000 feet and near the beginning of all branch lines.

(b) Trolley wires and trolley feeder wires shall be provided with overcurrent protection.

(c) Trolley wires and trolley feeder wires, high-voltage cables and transformers shall not be located in by the last open crosscut and shall be kept at least 150 feet from pillar workings.

(d) Trolley wires, trolley feeder wires, and bare signal wires shall be insulated adequately where they pass through doors and stoppings, and where they cross other power wires and cables. Trolley wires and trolley feeder wires shall be guarded adequately (1) at all points where men are required to work or pass regularly under the wires; (2) on both sides of all doors and stoppings; and (3) at man-trip stations. The Secretary or his authorized representatives shall specify other conditions where trolley wires and trolley feeder wires shall be adequately protected to prevent contact by any person, or shall require the use of improved methods to prevent such contact. Temporary guards shall be provided where trackmen and other persons work in proximity to trolley wires and trolley feeder wires.

FIRE PROTECTION

SEC. 311. (a) Each coal mine shall be provided with suitable fire-fighting equipment adapted for the size and conditions of the mine. The Secretary shall establish minimum requirements for the type,

quality, and quantity of such equipment, and the interpretations of the Secretary or the Director of the Bureau of Mines relating to such equipment in effect on the operative date of this title shall continue in effect until modified or superseded by the Secretary. After every blasting operation, an examination shall be made to determine whether fires have been started.

(b) Underground storage places for lubricating oil and grease shall be of fireproof construction. Except for specially prepared materials approved by the Secretary, lubricating oil and grease kept in all underground areas in a coal mine shall be in fireproof, closed metal containers or other no less effective containers approved by the Secretary.

(c) Underground transformer stations, battery-charging stations, substations, compressor stations, shops, and permanent pumps shall be housed in fireproof structures or areas. Air currents used to ventilate structures or areas enclosing electrical installations shall be coursed directly into the return. Other underground structures installed in a coal mine as the Secretary may prescribe shall be of fireproof construction.

(d) All welding, cutting, or soldering with arc or flame in all underground areas of a coal mine shall, whenever practicable, be conducted in fireproof enclosures. Welding, cutting or soldering with arc or flame in other than a fireproof enclosure shall be done under the supervision of a qualified person who shall make a diligent search for fire during and after such operations and shall, immediately before and during such operations, continuously test for methane with means approved by the Secretary for detecting methane. Welding, cutting, or soldering shall not be conducted in air that contains 1.0 volume per centum or more of methane. Rock dust or suitable fire extinguishers shall be immediately available during such welding, cutting, or soldering.

(e) Within one year after the operative date of this title, fire suppression devices meeting specifications prescribed by the Secretary shall be installed on unattended underground equipment and suitable fire-resistant hydraulic fluids approved by the Secretary shall be used in the hydraulic systems of such equipment. Such fluids shall be used in the hydraulic systems of other underground equipment unless fire suppression devices meeting specifications prescribed by the Secretary are installed on such equipment.

(f) Deluge-type water sprays or foam generators automatically actuated by rise in temperature, or other no less effective means approved by the Secretary of controlling fire, shall be installed at main and secondary belt-conveyor drives. Where sprays or foam generators are used they shall supply a sufficient quantity of water or foam to control fires.

(g) Underground belt conveyors shall be equipped with slippage and sequence switches. The Secretary shall, within sixty days after the operative date of this title, require that devices be installed on all such belts which will give a warning automatically when a fire occurs on or near such belt. The Secretary shall prescribe a schedule for installing fire suppression devices on belt haulageways.

(h) On and after the operative date of this title, all conveyor belts acquired for use underground shall meet the requirements to be established by the Secretary for flame-resistant conveyor belts.

MAPS

SEC. 312. (a) The operator of a coal mine shall have in a fireproof repository located in an area on the surface of the mine chosen by the mine operator to minimize the danger of destruction by fire or other hazard, an accurate and up-to-date map of such mine drawn on scale. Such map shall show the active workings, all pillared, worked out, and abandoned areas, except as provided in this section, entries and air-courses with the direction of airflow indicated by arrows, contour lines of all elevations, elevations of all main and cross or side entries, dip of the coalbed, escapeways, adjacent mine workings within one thousand feet, mines above or below, water pools above, and either producing or abandoned oil and gas wells located within five hundred feet of such mine and any underground area of such mine, and such other information as the Secretary may require. Such map shall identify those areas of the mine which have been pillared, worked out, or abandoned which are inaccessible or cannot be entered safely and on which no information is available. Such map shall be made or certified by a registered engineer or a registered surveyor of the State in which the mine is located. Such map shall be kept up to date by temporary notations and such map shall be revised and supplemented at intervals prescribed by the Secretary on the basis of a survey made or certified by such engineer or surveyor.

(b) The coal mine map and any revision and supplement thereof shall be available for inspection by the Secretary or his authorized representative, by coal mine inspectors of the State in which the mine is located, by miners in the mine and their representatives and by operators of adjacent coal mines and by persons owning, leasing, or residing on surface areas of such mines or areas adjacent to such mines. The operator shall furnish to the Secretary or his authorized representative and to the Secretary of Housing and Urban Development, upon request, one or more copies of such map and any revision and supplement thereof. Such map or revision and supplement thereof shall be kept confidential and its contents shall not be divulged to any other person, except to the extent necessary to carry out the provisions of this Act and in connection with the functions and responsibilities of the Secretary of Housing and Urban Development.

Availability.

(c) Whenever an operator permanently closes or abandons a coal mine, or temporarily closes a coal mine for a period of more than ninety days, he shall promptly notify the Secretary of such closure. Within sixty days of the permanent closure or abandonment of the mine, or, when the mine is temporarily closed, upon the expiration of a period of ninety days from the date of closure, the operator shall file with the Secretary a copy of the mine map revised and supplemented to the date of the closure. Such copy of the mine map shall be certified by a registered surveyor or registered engineer of the State in which the mine is located and shall be available for public inspection.

Mine closure.

BLASTING AND EXPLOSIVES

SEC. 313. (a) Black blasting powder shall not be stored or used underground. Mudcaps (adobes) or other unconfined shots shall not be fired underground.

(b) Explosives and detonators shall be kept in separate containers until immediately before blasting. In underground anthracite mines, (1) mudcaps or other open, unconfined shake shots may be fired, if

restricted to battery starting when methane or a fire hazard is not present, and if it is otherwise impracticable to start the battery; (2) open, unconfined shake shots in pitching veins may be fired, when no methane or fire hazard is present, if the taking down of loose hanging coal by other means is too hazardous; and (3) tests for methane shall be made immediately before such shots are fired and if 1.0 volume per centum or more of methane is present, when tested, such shot shall not be made until the methane content is reduced below 1.0 volume per centum.

(c) Except as provided in this subsection, in all underground areas of a coal mine only permissible explosives, electric detonators of proper strength, and permissible blasting devices shall be used and all explosives and blasting devices shall be used in a permissible manner. Permissible explosives shall be fired only with permissible shot firing units. Only incombustible materials shall be used for stemming boreholes. The Secretary may, under such safeguards as he may prescribe, permit the firing of more than twenty shots and allow the use of non-permissible explosives in sinking shafts and slopes from the surface in rock. Nothing in this section shall prohibit the use of compressed air blasting.

(d) Explosives or detonators carried anywhere underground in a coal mine by any person shall be in containers constructed of non-conductive material, maintained in good condition, and kept closed.

(e) Explosives or detonators shall be transported in special closed containers (1) in cars moved by means of a locomotive or rope, (2) on belts, (3) in shuttle cars, or (4) in equipment designed especially to transport such explosives or detonators.

(f) When supplies of explosives and detonators for use in one or more working sections are stored underground, they shall be kept in section boxes or magazines of substantial construction with no metal exposed on the inside, located at least twenty-five feet from roadways and power wires, and in a dry, well rock-dusted location protected from falls of roof, except in pitching beds, where it is not possible to comply with the location requirement, such boxes shall be placed in niches cut into the solid coal or rock.

(g) Explosives and detonators stored in the working places shall be kept in separate closed containers which shall be located out of the line of blast and not less than fifty feet from the working face and fifteen feet from any pipeline, powerline, rail, or conveyor, except that, if kept in niches in the rib, the distance from any pipeline, powerline, rail, or conveyor shall be at least five feet. Such explosives and detonators, when stored, shall be separated by a distance of at least five feet.

HOISTING AND MANTRIPS

SEC. 314 (a) Every hoist used to transport persons at a coal mine shall be equipped with overspeed, overwind, and automatic stop controls. Every hoist handling platforms, cages, or other devices used to transport persons shall be equipped with brakes capable of stopping the fully loaded platform, cage, or other device; with hoisting cable adequately strong to sustain the fully loaded platform, cage, or other device; and have a proper margin of safety. Cages, platforms, or other devices which are used to transport persons in shafts and slopes shall be equipped with safety catches or other no less effective devices approved by the Secretary that act quickly and effectively in an emergency, and such catches shall be tested at least once every two months. Hoisting equipment, including automatic elevators, that is

used to transport persons shall be examined daily. Where persons are transported into, or out of, a coal mine by hoists, a qualified hoisting engineer shall be on duty while any person is underground, except that no such engineer shall be required for automatically operated cages, platforms, or elevators.

(b) Other safeguards adequate, in the judgment of an authorized representative of the Secretary, to minimize hazards with respect to transportation of men and materials shall be provided.

(c) Hoists shall have rated capacities consistent with the loads handled and the recommended safety factors of the ropes used. An accurate and reliable indicator of the position of the cage, platform, skip, bucket, or cars shall be provided.

(d) There shall be at least two effective methods approved by the Secretary of signaling between each of the shaft stations and the hoist room, one of which shall be a telephone or speaking tube.

(e) Each locomotive and haulage car used in an underground coal mine shall be equipped with automatic brakes, where space permits. Where space does not permit automatic brakes, locomotives and haulage cars shall be subject to speed reduction gear, or other similar devices approved by the Secretary which are designed to stop the locomotives and haulage cars with the proper margin of safety.

(f) All haulage equipment acquired by an operator of a coal mine on or after one year after the operative date of this title shall be equipped with automatic couplers which couple by impact and uncouple without the necessity of persons going between the ends of such equipment. All haulage equipment without automatic couplers in use in a mine on the operative date of this title shall also be so equipped within four years after the operative date of this title.

EMERGENCY SHELTERS

SEC. 315. The Secretary or an authorized representative of the Secretary may prescribe in any coal mine that rescue chambers, properly sealed and ventilated, be erected at suitable locations in the mine to which persons may go in case of an emergency for protection against hazards. Such chambers shall be properly equipped with first aid materials, an adequate supply of air and self-contained breathing equipment, an independent communication system to the surface, and proper accommodations for the persons while awaiting rescue, and such other equipment as the Secretary may require. A plan for the erection, maintenance, and revisions of such chambers and the training of the miners in their proper use shall be submitted by the operator to the Secretary for his approval.

COMMUNICATIONS

SEC. 316. Telephone service or equivalent two-way communication facilities, approved by the Secretary or his authorized representative, shall be provided between the surface and each landing of main shafts and slopes and between the surface and each working section of any coal mine that is more than one hundred feet from a portal.

MISCELLANEOUS

SEC. 317. (a) Each operator of a coal mine shall take reasonable measures to locate oil and gas wells penetrating coalbeds or any underground area of a coal mine. When located, such operator shall establish and maintain barriers around such oil and gas wells in accordance

Oil and gas
wells.

with State laws and regulations, except that such barriers shall not be less than three hundred feet in diameter, unless the Secretary or his authorized representative permits a lesser barrier consistent with the applicable State laws and regulations where such lesser barrier will be adequate to protect against hazards from such wells to the miners in such mine, or unless the Secretary or his authorized representative requires a greater barrier where the depth of the mine, other geologic conditions, or other factors warrant such a greater barrier.

Boreholes.

(b) Whenever any working place approaches within fifty feet of abandoned areas in the mine as shown by surveys made and certified by a registered engineer or surveyor, or within two hundred feet of any other abandoned areas of the mine which cannot be inspected and which may contain dangerous accumulations of water or gas, or within two hundred feet of any workings of an adjacent mine, a borehole or boreholes shall be drilled to a distance of at least twenty feet in advance of the working face of such working place and shall be continually maintained to a distance of at least ten feet in advance of the advancing working face. When there is more than one borehole, they shall be drilled sufficiently close to each other to insure that the advancing working face will not accidentally hole through into abandoned areas or adjacent mines. Boreholes shall also be drilled not more than eight feet apart in the rib of such working place to a distance of at least twenty feet and at an angle of forty-five degrees. Such rib holes shall be drilled in one or both ribs of such working place as may be necessary for adequate protection of miners in such place.

Smoking,
prohibition.

(c) No person shall smoke, carry smoking materials, matches, or lighters underground, or smoke in or around oil houses, explosives magazines, or other surface areas where such practice may cause a fire or explosion. The operator shall institute a program, approved by the Secretary, to insure that any person entering the underground area of the mine does not carry smoking materials, matches, or lighters.

Portable
electric lamps.

(d) Persons underground shall use only permissible electric lamps approved by the Secretary for portable illumination. No open flame shall be permitted in the underground area of any coal mine, except as permitted under section 311(d) of this title.

(e) Within nine months after the operative date of this title, the Secretary shall propose the standards under which all working places in a mine shall be illuminated by permissible lighting, within eighteen months after the promulgation of such standards, while persons are working in such places.

(f) (1) Except as provided in paragraphs (2) and (3) of this subsection, at least two separate and distinct travelable passageways which are maintained to insure passage at all times of any person, including disabled persons, and which are to be designated as escapeways, at least one of which is ventilated with intake air, shall be provided from each working section continuous to the surface escape drift opening, or continuous to the escape shaft or slope facilities to the surface, as appropriate, and shall be maintained in safe condition and properly marked. Mine openings shall be adequately protected to prevent the entrance into the underground area of the mine of surface fires, fumes, smoke, and flood water. Escape facilities approved by the Secretary or his authorized representative, properly maintained and frequently tested, shall be present at or in each escape shaft or slope to allow all persons, including disabled persons, to escape quickly to the surface in the event of an emergency.

(2) When new coal mines are opened, not more than twenty miners shall be allowed at any one time in any mine until a connection has

been made between the two mine openings, and such connections shall be made as soon as possible.

(3) When only one mine opening is available, owing to final mining of pillars, not more than twenty miners shall be allowed in such mine at any one time, and the distance between the mine opening and working face shall not exceed five hundred feet.

(4) In the case of all coal mines opened on or after the operative date of this title, and in the case of all new working sections opened on or after such date in mines opened prior to such date, the escapeway required by this section to be ventilated with intake air shall be separated from the belt and trolley haulage entries of the mine for the entire length of such entries to the beginning of each working section, except that the Secretary or his authorized representative may permit such separation to be extended for a greater or lesser distance so long as such extension does not pose a hazard to the miners.

(g) After the operative date of this title, all structures erected on the surface within one hundred feet of any mine opening shall be of fireproof construction. Unless structures existing on or prior to such date which are located within one hundred feet of any mine opening are of such construction, fire doors shall be erected at effective points in mine openings to prevent smoke or fire from outside sources endangering miners underground. These doors shall be tested at least monthly to insure effective operation. A record of such tests shall be kept in an area on the surface of the mine chosen by the operator to minimize the danger of destruction by fire or other hazard and shall be available for inspection by interested persons.

Surface
structures,
fireproofing.

(h) Adequate measures shall be taken to prevent methane and coal dust from accumulating in excessive concentrations in or on surface coal-handling facilities, but in no event shall methane be permitted to accumulate in concentrations in or on surface coal-handling facilities in excess of limits established for methane by the Secretary within one year after the operative date of this title. Where coal is dumped at or near air-intake openings, provisions shall be made to avoid dust from entering the mine.

(i) Every operator of a coal mine shall provide a program, approved by the Secretary, of training and retraining of both qualified and certified persons needed to carry out functions prescribed in this Act.

Training
programs.

(j) An authorized representative of the Secretary may require in any coal mine where the height of the coalbed permits that electric face equipment, including shuttle cars, be provided with substantially constructed canopies or cabs to protect the miners operating such equipment from roof falls and from rib and face rolls.

(k) On and after the operative date of this title, the opening of any coal mine that is declared inactive by its operator or is permanently closed or abandoned for more than ninety days, shall be sealed by the operator in a manner prescribed by the Secretary. Openings of all other mines shall be adequately protected in a manner prescribed by the Secretary to prevent entrance by unauthorized persons.

(l) The Secretary may require any operator to provide adequate facilities for the miners to change from the clothes worn underground, to provide for the storing of such clothes from shift to shift, and to provide sanitary and bathing facilities. Sanitary toilet facilities shall be provided in the active workings of the mine when such surface facilities are not readily accessible to the active workings.

(m) Each operator shall make arrangements in advance for obtaining emergency medical assistance and transportation for injured

Emergency
medical
assistance.

persons. Emergency communications shall be provided to the nearest point of assistance. Selected agents of the operator shall be trained in first aid and first aid training shall be made available to all miners. Each coal mine shall have an adequate supply of first aid equipment located on the surface, at the bottom of shafts and slopes, and at other strategic locations near the working faces. In fulfilling each of the requirements of this subsection, the operator shall meet at least minimum requirements prescribed by the Secretary of Health, Education, and Welfare. Within two months after the operative date of this title, each operator shall file with the Secretary a plan setting forth in such detail as the Secretary may require the manner in which such operator has fulfilled the requirements in this subsection.

Self-rescue
device.

(n) A self-rescue device approved by the Secretary shall be made available to each miner by the operator which shall be adequate to protect such miner for one hour or longer. Each operator shall train each miner in the use of such device.

(o) The Secretary shall prescribe improved methods of assuring that miners are not exposed to atmospheres that are deficient in oxygen.

Identification
check system.

(p) Each operator of a coal mine shall establish a check-in and check-out system which will provide positive identification of every person underground, and will provide an accurate record of the persons in the mine kept on the surface in a place chosen to minimize the danger of destruction by fire or other hazard. Such record shall bear a number identical to an identification check that is securely fastened to the lamp belt worn by the person underground. The identification check shall be made of a rust resistant metal of not less than sixteen gauge.

(q) The Secretary shall require, when technologically feasible, that devices to prevent and suppress ignitions be installed on electric face cutting equipment.

Tunnels under
water.

(r) Whenever an operator mines coal from a coal mine opened after the operative date of this title, or from any new working section of a mine opened prior to such date, in a manner that requires the construction, operation, and maintenance of tunnels under any river, stream, lake, or other body of water, that is, in the judgment of the Secretary, sufficiently large to constitute a hazard to miners, such operator shall obtain a permit from the Secretary which shall include such terms and conditions as he deems appropriate to protect the safety of miners working or passing through such tunnels from cave-ins and other hazards. Such permits shall require, in accordance with a plan to be approved by the Secretary, that a safety zone be established beneath and adjacent to such body of water. No plan shall be approved unless there is a minimum of cover to be determined by the Secretary, based on test holes drilled by the operator in a manner to be prescribed by the Secretary. No such permit shall be required in the case of any new working section of a mine which is located under any water resource reservoir being constructed by a Federal agency on the date of enactment of this Act, the operator of which is required by such agency to operate in a manner that adequately protects the safety of miners working in such section from cave-ins and other hazards.

Drinking water.

(s) An adequate supply of potable water shall be provided for drinking purposes in the active workings of the mine, and such water shall be carried, stored, and otherwise protected in sanitary containers.

(t) Within one year after the operative date of this title, the Secretary shall propose standards for preventing explosions from explosive gases other than methane and for testing for accumulations of such gases.

DEFINITIONS

SEC. 318. For the purpose of this title and title II of this Act, the term—

Ante, p.

(a) "certified" or "registered" as applied to any person means a person certified or registered by the State in which the coal mine is located to perform duties prescribed by such titles, except that, in a State where no program of certification or registration is provided or where the program does not meet at least minimum Federal standards established by the Secretary, such certification or registration shall be by the Secretary;

(b) "qualified person" means, as the context requires,

(1) an individual deemed qualified by the Secretary and designated by the operator to make tests and examinations required by this Act; and

(2) an individual deemed, in accordance with minimum requirements to be established by the Secretary, qualified by training, education, and experience, to perform electrical work, to maintain electrical equipment, and to conduct examinations and tests of all electrical equipment;

(c) "permissible" as applied to—

(1) equipment used in the operation of a coal mine, means equipment, other than permissible electric face equipment, to which an approval plate, label, or other device is attached as authorized by the Secretary and which meets specifications which are prescribed by the Secretary for the construction and maintenance of such equipment and are designed to assure that such equipment will not cause a mine explosion or a mine fire,

(2) explosives, shot firing units, or blasting devices used in such mine, means explosives, shot firing units, or blasting devices which meet specifications which are prescribed by the Secretary, and

(3) the manner of use of equipment or explosives, shot firing units, and blasting devices, means the manner of use prescribed by the Secretary;

(d) "rock dust" means pulverized limestone, dolomite, gypsum, anhydrite, shale, adobe, or other inert material, preferably light colored, 100 per centum of which will pass through a sieve having twenty meshes per linear inch and 70 per centum or more of which will pass through a sieve having two hundred meshes per linear inch; the particles of which when wetted and dried will not cohere to form a cake which will not be dispersed into separate particles by a light blast of air; and which does not contain more than 5 per centum of combustible matter or more than a total of 4 per centum of free and combined silica (SiO_2), or, where the Secretary finds that such silica concentrations are not available, which does not contain more than 5 per centum of free and combined silica;

(e) "anthracite" means coals with a volatile ratio equal to 0.12 or less;

(f) "volatile ratio" means volatile matter content divided by the volatile matter plus the fixed carbon;

(g) (1) "working face" means any place in a coal mine in which work of extracting coal from its natural deposit in the earth is performed during the mining cycle,

(2) "working place" means the area of a coal mine inby the last open crosscut,

(3) "working section" means all areas of the coal mine from the loading point of the section to and including the working faces,

(4) "active workings" means any place in a coal mine where miners are normally required to work or travel;

(h) "abandoned areas" means sections, panels, and other areas that are not ventilated and examined in the manner required for working places under section 303 of this title;

(i) "permissible" as applied to electric face equipment means all electrically operated equipment taken into or used inby the last open crosscut of an entry or a room of any coal mine the electrical parts of which, including, but not limited to, associated electrical equipment, components, and accessories, are designed, constructed, and installed, in accordance with the specifications of the Secretary, to assure that such equipment will not cause a mine explosion or mine fire, and the other features of which are designed and constructed, in accordance with the specifications of the Secretary, to prevent, to the greatest extent possible, other accidents in the use of such equipment; and the regulations of the Secretary or the Director of the Bureau of Mines in effect on the operative date of this title relating to the requirements for investigation, testing, approval, certification, and acceptance of such equipment as permissible shall continue in effect until modified or superseded by the Secretary, except that the Secretary shall provide procedures, including, where feasible, testing, approval, certification, and acceptance in the field by an authorized representative of the Secretary, to facilitate compliance by an operator with the requirements of section 305(a) of this title within the periods prescribed therein;

(j) "low voltage" means up to and including 660 volts; "medium voltage" means voltages from 661 to 1,000 volts; and "high voltage" means more than 1,000 volts;

(k) "respirable dust" means only dust particulates 5 microns or less in size; and

(l) "coal mine" includes areas of adjoining mines connected underground.

TITLE IV—BLACK LUNG BENEFITS

PART A—GENERAL

SEC. 401. Congress finds and declares that there are a significant number of coal miners living today who are totally disabled due to pneumoconiosis arising out of employment in one or more of the Nation's underground coal mines; that there are a number of survivors of coal miners whose deaths were due to this disease; and that few States provide benefits for death or disability due to this disease to coal miners or their surviving dependents. It is, therefore, the purpose of this title to provide benefits, in cooperation with the States, to coal miners who are totally disabled due to pneumoconiosis and to the surviving dependents of miners whose death was due to such disease; and to ensure that in the future adequate benefits are provided to coal miners and their dependents in the event of their death or total disability due to pneumoconiosis.

SEC. 402. For purposes of this title—

Definitions.

Ante, p. 775.

(a) The term "dependent" means a wife or child who is a dependent as that term is defined for purposes of section 8110 of title 5, United States Code.

80 Stat. 539;

(b) The term "pneumoconiosis" means a chronic dust disease of the lung arising out of employment in an underground coal mine.

81 Stat. 210.

(c) The term "Secretary" where used in part B means the Secretary of Health, Education, and Welfare, and where used in part C means the Secretary of Labor.

(d) The term "miner" means any individual who is or was employed in an underground coal mine.

(e) The term "widow" means the wife living with or dependent for support on the decedent at the time of his death, or living apart for reasonable cause or because of his desertion, who has not remarried.

(f) The term "total disability" has the meaning given it by regulations of the Secretary of Health, Education, and Welfare, but such regulations shall not provide more restrictive criteria than those applicable under section 223(d) of the Social Security Act.

81 Stat. 868.

42 USC 423.

PART B—CLAIMS FOR BENEFITS FILED ON OR BEFORE DECEMBER 31, 1972

SEC. 411. (a) The Secretary shall, in accordance with the provisions of this part, and the regulations promulgated by him under this part, make payments of benefits in respect of total disability of any miner due to pneumoconiosis, and in respect of the death of any miner whose death was due to pneumoconiosis.

(b) The Secretary shall by regulation prescribe standards for determining for purposes of section 411(a) whether a miner is totally disabled due to pneumoconiosis and for determining whether the death of a miner was due to pneumoconiosis. Regulations required by this subsection shall be promulgated and published in the Federal Register at the earliest practicable date after the date of enactment of this title, and in no event later than the end of the third month following the month in which this title is enacted. Such regulations may be modified or additional regulations promulgated from time to time thereafter.

Publication
in Federal
Register.

(c) For purposes of this section—

(1) if a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more underground coal mines there shall be a rebuttable presumption that his pneumoconiosis arose out of such employment;

(2) if a deceased miner was employed for ten years or more in one or more underground coal mines and died from a respirable disease there shall be a rebuttable presumption that his death was due to pneumoconiosis; and

(3) if a miner is suffering or suffered from a chronic dust disease of the lung which (A) when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C in the International Classification of Radiographs of the Pneumoconioses by the International Labor Organization, (B) when diagnosed by biopsy or autopsy, yields massive lesions in the lung, or (C) when diagnosis is made by other means, would be a condition which could reasonably be expected to yield results described in clause (A) or (B) if diagnosis had been made in the manner prescribed in clause (A) or (B), then there shall be an irrebuttable presumption that he is totally disabled due to pneumoconiosis or that his death was due to pneumoconiosis, as the case may be.

(d) Nothing in subsection (c) shall be deemed to affect the applicability of subsection (a) in the case of a claim where the presumptions provided for therein are inapplicable.

SEC. 412. (a) Subject to the provisions of subsection (b) of this section, benefit payments shall be made by the Secretary under this part as follows:

(1) In the case of total disability of a miner due to pneumoconiosis, the disabled miner shall be paid benefits during the disability at a rate equal to 50 per centum of the minimum monthly payment to which a Federal employee in grade GS-2, who is totally disabled, is entitled at the time of payment under chapter 81 of title 5, United States Code.

(2) In the case of death of a miner due to pneumoconiosis or of a miner receiving benefits under this part, benefits shall be paid to his widow (if any) at the rate the deceased miner would receive such benefits if he were totally disabled.

(3) In the case of an individual entitled to benefit payments under clause (1) or (2) of this subsection who has one or more dependents, the benefit payments shall be increased at the rate of 50 per centum of such benefit payments, if such individual has one dependent, 75 per centum if such individual has two dependents, and 100 per centum if such individual has three or more dependents.

(b) Notwithstanding subsection (a), benefit payments under this section to a miner or his widow shall be reduced, on a monthly or other appropriate basis, by an amount equal to any payment received by such miner or his widow under the workmen's compensation, unemployment compensation, or disability insurance laws of his State on account of the disability of such miner, and the amount by which such payment would be reduced on account of excess earnings of such miner under section 203(b) through (l) of the Social Security Act if the amount paid were a benefit payable under section 202 of such Act.

(c) Benefits payable under this part shall be deemed not to be income for purposes of the Internal Revenue Code of 1954.

SEC. 413. (a) Except as otherwise provided in section 414 of this part, no payment of benefits shall be made under this part except pursuant to a claim filed therefor on or before December 31, 1972, in such manner, in such form, and containing such information, as the Secretary shall by regulation prescribe.

(b) In carrying out the provisions of this part, the Secretary shall to the maximum extent feasible (and consistent with the provisions of this part) utilize the personnel and procedures he uses in determining entitlement to disability insurance benefit payments under section 223 of the Social Security Act. Claimants under this part shall be reimbursed for reasonable medical expenses incurred by them in establishing their claims. For purposes of determining total disability under this part, the provisions of subsections (a), (b), (c), (d), and (g) of section 221 of such Act shall be applicable.

(c) No claim for benefits under this section shall be considered unless the claimant has also filed a claim under the applicable State workmen's compensation law prior to or at the same time his claim was filed for benefits under this section; except that the foregoing provisions of this paragraph shall not apply in any case in which the filing of a claim under such law would clearly be futile because the period within which such a claim may be filed thereunder has expired or because pneumoconiosis is not compensable under such law, or in any other situation in which, in the opinion of the Secretary, the filing of a claim would clearly be futile.

34 F.R. 9605.
5 USC 5332
note.
80 Stat. 532.
5 USC 8101-
8193.

42 USC 403.
42 USC 402.

68A Stat. 3.
26 USC 1 et
seq.

70 Stat. 815.
42 USC 423.

68 Stat. 1081.
42 USC 421.

SEC. 414. (a) No claim for benefits under this part on account of total disability of a miner shall be considered unless it is filed on or before December 31, 1972, or, in the case of a claimant who is a widow, within six months after the death of her husband or by December 31, 1972, whichever is the later.

(b) No benefits shall be paid under this part after December 31, 1972, if the claim therefor was filed after December 31, 1971.

(c) No benefits under this part shall be payable for any period prior to the date a claim therefor is filed.

(d) No benefits shall be paid under this part to the residents of any State which, after the date of enactment of this Act, reduces the benefits payable to persons eligible to receive benefits under this part, under its State laws which are applicable to its general work force with regard to workmen's compensation, unemployment compensation, or disability insurance.

(e) No benefits shall be payable to a widow under this part on account of the death of a miner unless (1) benefits under this part were being paid to such miner with respect to disability due to pneumoconiosis prior to his death, or (2) the death of such miner occurred prior to January 1, 1973.

PART C—CLAIMS FOR BENEFITS AFTER DECEMBER 31, 1972

SEC. 421. (a) On and after January 1, 1973, any claim for benefits for death or total disability due to pneumoconiosis shall be filed pursuant to the applicable State workmen's compensation law, except that during any period when miners or their surviving widows are not covered by a State workmen's compensation law which provides adequate coverage for pneumoconiosis they shall be entitled to claim benefits under this part.

(b) (1) For purposes of this section, a State workmen's compensation law shall not be deemed to provide adequate coverage for pneumoconiosis during any period unless it is included in the list of State laws found by the Secretary to provide such adequate coverage during such period. The Secretary shall, no later than October 1, 1972, publish in the Federal Register a list of State workmen's compensation laws which provide adequate coverage for pneumoconiosis and shall revise and republish in the Federal Register such list from time to time, as may be appropriate to reflect changes in such State laws due to legislation or judicial or administrative interpretation.

(2) The Secretary shall include a State workmen's compensation law on such list during any period only if he finds that during such period under such law—

(A) benefits must be paid for total disability or death of a miner due to pneumoconiosis;

(B) the amount of such cash benefits is substantially equivalent to or greater than the amount of benefits prescribed by section 412(a) of this title;

(C) the standards for determining death or total disability due to pneumoconiosis are substantially equivalent to those established by section 411, and by the regulations of the Secretary of Health, Education, and Welfare promulgated thereunder;

(D) any claim for benefits on account of total disability or death of a miner due to pneumoconiosis is deemed to be timely filed if such claim is filed within three years of the discovery of total disability due to pneumoconiosis, or the date of such death, as the case may be;

Publication in
Federal
Register.

(E) there are in effect provisions with respect to prior and successor operators which are substantially equivalent to the provisions contained in section 422(i) of this part; and

(F) there are applicable such other provisions, regulations or interpretations, which are consistent with the provisions contained in Public Law 803, 69th Congress (44 Stat. 1424, approved March 4, 1927), as amended, which are applicable under section 422(a), but are not inconsistent with any of the criteria set forth in subparagraphs (A) through (E) of this paragraph, as the Secretary, in accordance with regulations promulgated by him, determines to be necessary or appropriate to assure adequate compensation for total disability or death due to pneumoconiosis.

The action of the Secretary in including or failing to include any State workmen's compensation law on such list shall be subject to judicial review exclusively in the United States court of appeals for the circuit in which the State is located or the United States Court of Appeals for the District of Columbia.

SEC. 422. (a) During any period after December 31, 1972, in which a State workmen's compensation law is not included on the list published by the Secretary under section 421(b) of this part, the provisions of Public Law 803, 69th Congress (44 Stat. 1424, approved March 4, 1927), as amended (other than the provisions contained in sections 1, 2, 3, 4, 7, 8, 9, 10, 12, 13, 29, 30, 31, 32, 33, 37, 38, 41, 43, 44, 45, 46, 47, 48, 49, 50, and 51 thereof) shall (except as otherwise provided in this subsection and except as the Secretary shall by regulation otherwise provide), be applicable to each operator of an underground coal mine in such State with respect to death or total disability due to pneumoconiosis arising out of employment in such mine. In administering this part, the Secretary is authorized to prescribe in the Federal Register such additional provisions, not inconsistent with those specifically excluded by this subsection, as he deems necessary to provide for the payment of benefits by such operator to persons entitled thereto as provided in this part and thereafter those provisions shall be applicable to such operator.

(b) During any such period each such operator shall be liable for and shall secure the payment of benefits, as provided in this section and section 423 of this part.

(c) Benefits shall be paid during such period by each such operator under this section to the categories of persons entitled to benefits under section 412(a) of this title in accordance with the regulations of the Secretary and the Secretary of Health, Education, and Welfare applicable under this section: *Provided*, That, except as provided in subsection (i) of this section, no benefit shall be payable by any operator on account of death or total disability due to pneumoconiosis which did not arise, at least in part, out of employment in a mine during the period when it was operated by such operator.

(d) Benefits payable under this section shall be paid on a monthly basis and, except as otherwise provided in this section, such payments shall be equal to the amounts specified in section 412(a) of this title.

(e) No payment of benefits shall be required under this section:

(1) except pursuant to a claim filed therefor in such manner, in such form, and containing such information, as the Secretary shall by regulation prescribe;

(2) for any period prior to January 1, 1973; or

(3) for any period after seven years after the date of enactment of this Act.

(f) Any claim for benefits under this section shall be filed within three years of the discovery of total disability due to pneumoconiosis or, in the case of death due to pneumoconiosis, the date of such death.

(g) The amount of benefits payable under this section shall be reduced, on a monthly or other appropriate basis, by the amount of any compensation received under or pursuant to any Federal or State workmen's compensation law because of death or disability due to pneumoconiosis.

(h) The regulations of the Secretary of Health, Education, and Welfare promulgated under section 411 of this title shall also be applicable to claims under this section. The Secretary of Labor shall by regulation establish standards, which may include appropriate presumptions, for determining whether pneumoconiosis arose out of employment in a particular underground coal mine or mines. The Secretary may also, by regulation, establish standards for apportioning liability for benefits under this subsection among more than one operator, where such apportionment is appropriate.

(i) (1) During any period in which this section is applicable with respect to a coal mine an operator of such mine who, after the date of enactment of this title, acquired such mine or substantially all the assets thereof from a person (hereinafter referred to in this paragraph as a "prior operator") who was an operator of such mine on or after the operative date of this title shall be liable for and shall, in accordance with section 423 of this part, secure the payment of all benefits which would have been payable by the prior operator under this section with respect to miners previously employed in such mine if the acquisition had not occurred and the prior operator had continued to operate such mine.

(2) Nothing in this subsection shall relieve any prior operator of any liability under this section.

SEC. 423. (a) During any period in which a State workmen's compensation law is not included on the list published by the Secretary under section 421(b) each operator of an underground coal mine in such State shall secure the payment of benefits for which he is liable under section 422 by (1) qualifying as a self-insurer in accordance with regulations prescribed by the Secretary, or (2) insuring and keeping insured the payment of such benefits with any stock company or mutual company or association, or with any other person or fund, including any State fund, while such company, association, person or fund is authorized under the laws of any State to insure workmen's compensation.

(b) In order to meet the requirements of clause (2) of subsection (a) of this section, every policy or contract of insurance must contain—

(1) a provision to pay benefits required under section 422, notwithstanding the provisions of the State workmen's compensation law which may provide for lesser payments;

(2) a provision that insolvency or bankruptcy of the operator or discharge therein (or both) shall not relieve the carrier from liability for such payments; and

(3) such other provisions as the Secretary, by regulation, may require.

(c) No policy or contract of insurance issued by a carrier to comply with the requirements of clause (2) of subsection (a) of this subsection shall be canceled prior to the date specified in such policy or contract for its expiration until at least thirty days have elapsed after

notice of cancellation has been sent by registered or certified mail to the Secretary and to the operator at his last known place of business.

SEC. 424. If a totally disabled miner or a widow is entitled to benefits under section 422 and (1) an operator liable for such benefits has not obtained a policy or contract of insurance, or qualified as a self-insurer, as required by section 423, or such operator has not paid such benefits within a reasonable time, or (2) there is no operator who was required to secure the payment of such benefits, the Secretary shall pay such miner or such widow the benefits to which he or she is so entitled. In a case referred to in clause (1), the operator shall be liable to the United States in a civil action in an amount equal to the amount paid to such miner or his widow under this title.

SEC. 425. With the consent and cooperation of State agencies charged with administration of State workmen's compensation laws, the Secretary may, for the purpose of carrying out his functions and duties under section 422, utilize the services of State and local agencies and their employees and, notwithstanding any other provision of law, may advance funds to or reimburse such State and local agencies and their employees for services rendered for such purposes.

SEC. 426. (a) The Secretary of Labor and the Secretary of Health, Education, and Welfare are authorized to issue such regulations as each deems appropriate to carry out the provisions of this title. Such regulations shall be issued in conformity with section 553 of title 5 of the United States Code, notwithstanding subsection (a) thereof.

(b) Within 120 days following the convening of each session of Congress the Secretary of Health, Education, and Welfare shall submit to the Congress an annual report upon the subject matter of part B of this title, and, after January 1, 1973, the Secretary of Labor shall also submit such a report upon the subject matter of part C of this title.

(c) Nothing in this title shall relieve any operator of the duty to comply with any State workmen's compensation law, except insofar as such State law is in conflict with the provisions of this title and the Secretary by regulation, so prescribes. The provisions of any State workmen's compensation law which provide greater benefits than the benefits payable under this title shall not thereby be construed or held to be in conflict with the provisions of this title.

TITLE V—ADMINISTRATION

RESEARCH

SEC. 501. (a) The Secretary and the Secretary of Health, Education, and Welfare, as appropriate, shall conduct such studies, research, experiments, and demonstrations as may be appropriate—

(1) to improve working conditions and practices in coal mines, and to prevent accidents and occupational diseases originating in the coal-mining industry;

(2) to develop new or improved methods of recovering persons in coal mines after an accident;

(3) to develop new or improved means and methods of communication from the surface to the underground area of a coal mine;

(4) to develop new or improved means and methods of reducing concentrations of respirable dust in the mine atmosphere of active workings of the coal mine;

(5) to develop epidemiological information to (A) identify and define positive factors involved in occupational diseases of miners, (B) provide information on the incidence and prevalence of pneumoconiosis and other respiratory ailments of miners, and (C) improve mandatory health standards;

(6) to develop techniques for the prevention and control of occupational diseases of miners, including tests for hypersusceptibility and early detection;

(7) to evaluate the effect on bodily impairment and occupational disability of miners afflicted with an occupational disease;

(8) to prepare and publish from time to time, reports on all significant aspects of occupational diseases of miners as well as on the medical aspects of injuries, other than diseases, which are revealed by the research carried on pursuant to this subsection;

(9) to study the relationship between coal mine environments and occupational diseases of miners;

(10) to develop new and improved underground equipment and other sources of power for such equipment which will provide greater safety; and

(11) for such other purposes as they deem necessary to carry out the purposes of this Act.

(b) Activities under this section in the field of coal mine health shall be carried out by the Secretary of Health, Education, and Welfare, and activities under this section in the field of coal mine safety shall be carried out by the Secretary.

(c) In carrying out the provisions for research, demonstrations, experiments, studies, training, and education under this section and sections 301(b) and 502(a) of this Act, the Secretary and the Secretary of Health, Education, and Welfare may enter into contracts with, and make grants to, public and private agencies and organizations and individuals. No research, demonstrations, or experiments shall be carried out, contracted for, sponsored, cosponsored, or authorized under authority of this Act, unless all information, uses, products, processes, patents, and other developments resulting from such research, demonstrations, or experiments will (with such exception and limitation, if any, as the Secretary or the Secretary of Health, Education, and Welfare may find to be necessary in the public interest) be available to the general public.

(d) The Secretary of Health, Education, and Welfare shall also conduct studies and research into matters involving the protection of life and the prevention of diseases in connection with persons, who although not miners, work with, or around the products of, coal mines in areas outside of such mines and under conditions which may adversely affect the health and well-being of such persons.

(e) There is authorized to be appropriated to the Secretary such sums as may be necessary to carry out his responsibilities under this section and section 301(b) of this Act at an annual rate of not to exceed \$20,000,000 for the fiscal year ending June 30, 1970, \$25,000,000 for the fiscal year ending June 30, 1971, and \$30,000,000 for the fiscal year ending June 30, 1972, and for each succeeding fiscal year thereafter. There is authorized to be appropriated annually to the Secretary of Health, Education, and Welfare such sums as may be necessary to carry out his responsibilities under this Act. Such sums shall remain available until expended.

(f) The Secretary is authorized to grant on a mine-by-mine basis an exception to any mandatory health or safety standard under this

Availability of
information.

Studies.

Appropriation.

Exceptions.

Act for the purpose of permitting, under such terms and conditions as he may prescribe, accredited educational institutions the opportunity for experimenting with new and improved techniques and equipment to improve the health and safety of miners. No such exception shall be granted unless the Secretary finds that the granting of the exception will not adversely affect the health and safety of miners and publishes his findings.

(g) The Secretary of Health, Education, and Welfare is authorized to make grants to any public or private agency, institution, or organization, and operators or individuals for research and experiments to develop effective respiratory equipment.

TRAINING AND EDUCATION

SEC. 502. (a) The Secretary shall expand programs for the education and training of operators and agents thereof, and miners in—

(1) the recognition, avoidance, and prevention of accidents or unsafe or unhealthful working conditions in coal mines; and

(2) in the use of flame safety lamps, permissible methane detectors, and other means approved by the Secretary for detecting methane and other explosive gases accurately.

(b) The Secretary shall, to the greatest extent possible, provide technical assistance to operators in meeting the requirements of this Act and in further improving the health and safety conditions and practices in coal mines.

ASSISTANCE TO STATES

SEC. 503. (a) The Secretary, in coordination with the Secretary of Health, Education, and Welfare and the Secretary of Labor, is authorized to make grants in accordance with an application approved under this section to any State in which coal mining takes place—

(1) to assist such State in developing and enforcing effective coal mine health and safety laws and regulations consistent with the provisions of section 506 of this Act;

(2) to improve State workmen's compensation and occupational disease laws and programs related to coal mine employment; and

(3) to promote Federal-State coordination and cooperation in improving the health and safety conditions in the coal mines.

(b) The Secretary shall approve any application or any modification thereof, submitted under this section by a State, through its official coal mine inspection or safety agency, which—

(1) sets forth the programs, policies, and methods to be followed in carrying out the application in accordance with the purposes of subsection (a) of this section;

(2) provides research and planning studies to carry out plans designed to improve State workmen's compensation and occupational disease laws and programs, as they relate to compensation to miners for occupationally caused diseases and injuries arising out of employment in any coal mine;

(3) designates such State coal mine inspection or safety agency as the sole agency responsible for administering grants under this section throughout the State, and contains satisfactory evidence that such agency will have the authority to carry out the purposes of this section;

(4) gives assurances that such agency has or will employ an adequate and competent staff of trained inspectors qualified under the laws of such State to make coal mine inspections within such State;

(5) provides for the extension and improvement of the State program for the improvement of coal mine health and safety in the State, and provides that no advance notice of an inspection will be provided anyone;

(6) provides such fiscal control and fund accounting procedures as may be appropriate to assure proper disbursement and accounting of grants made to the States under this section;

(7) provides that the designated agency will make such reports to the Secretary in such form and containing such information as the Secretary may from time to time require;

(8) contains assurances that grants provided under this section will supplement, not supplant, existing State coal mine health and safety programs; and

(9) meets additional conditions which the Secretary may prescribe in furtherance of, and consistent with, the purposes of this section.

(c) The Secretary shall not finally disapprove any State application or modification thereof without first affording the State agency reasonable notice and opportunity for a public hearing.

(d) Any State aggrieved by a decision of the Secretary under subsection (b) or (c) of this section may file within thirty days from the date of such decision with the United States Court of Appeals for the District of Columbia a petition praying that such action be modified or set aside in whole or in part. The court shall hear such appeal on the record made before the Secretary. The decision of the Secretary incorporating his findings of fact therein, if supported by substantial evidence on the record considered as a whole, shall be conclusive. The court may affirm, vacate, or remand the proceedings to the Secretary for such further action as it directs. The filing of a petition under this subsection shall not stay the application of the decision of the Secretary, unless the court so orders. The provisions of section 106 (a), (b), and (c) of this Act shall not be applicable to this section.

(e) Any State application or modification thereof submitted to the Secretary under this section may include a program to train State inspectors.

(f) The Secretary shall cooperate with such State in carrying out the application or modification thereof and shall, as appropriate, develop and, where appropriate, construct facilities for, and finance a program of, training of Federal and State inspectors jointly. The Secretary shall also cooperate with such State in establishing a system by which State and Federal inspection reports of coal mines located in the State are exchanged for the purpose of improving health and safety conditions in such mines.

(g) The amount granted to any coal mining State for a fiscal year under this section shall not exceed 80 per centum of the amount expended by such State in such year for carrying out such application.

(h) There is authorized to be appropriated \$3,000,000 for fiscal year 1970, and \$5,000,000 annually in each succeeding fiscal year to carry out the provisions of this section, which shall remain available until expended. The Secretary shall provide for an equitable distribution of sums appropriated for grants under this section to the States where there is an approved application.

Appropriation.

ECONOMIC ASSISTANCE

72 Stat. 387.
15 USC 636.

SEC. 504. (a) Section 7(b) of the Small Business Act, as amended, is amended—

(1) by striking out the period at the end of paragraph (4) and inserting in lieu thereof “; and”; and

(2) by adding after paragraph (4) a new paragraph as follows:

“(5) to make such loans (either directly or in cooperation with banks or other lending institutions through agreements to participate on an immediate or deferred basis) as the Administration may determine to be necessary or appropriate to assist any small business concern operating a coal mine in affecting additions to or alterations in the equipment, facilities, or methods of operation of such mine to requirements imposed by the Federal Coal Mine Health and Safety Act of 1969, if the Administration determines that such concern is likely to suffer substantial economic injury without assistance under this paragraph.”

(b) The third sentence of section 7(b) of such Act is amended by inserting “or (5)” after “paragraph (3)”.

(c) Section 4(c)(1) of the Small Business Act, as amended, is amended by inserting “7(b)(5),” after “7(b)(4),”.

(d) Loans may also be made or guaranteed for the purposes set forth in section 7(b)(5) of the Small Business Act, as amended pursuant to the provisions of section 202 of the Public Works and Economic Development Act of 1965, as amended.

79 Stat. 556.
42 USC 3142.

INSPECTORS: QUALIFICATIONS: TRAINING

SEC. 505. The Secretary may, subject to the civil service laws, appoint such employees as he deems requisite for the administration of this Act and prescribe their duties. Persons appointed as authorized representatives of the Secretary shall be qualified by practical experience in the mining of coal or by experience as a practical mining engineer or by education. Persons appointed to assist such representatives in the taking of samples of respirable dust for the purpose of enforcing title II of this Act shall be qualified by training, experience, or education. The provisions of section 201 of the Revenue and Expenditure Control Act of 1968 (82 Stat. 251, 270) shall not apply with respect to the appointment of such authorized representatives of the Secretary or to persons appointed to assist such representatives and to carry out the provisions of this Act, and, in applying the provisions of such section to other agencies under the Secretary and to other agencies of the Government, such appointed persons shall not be taken into account. Such persons shall be adequately trained by the Secretary. The Secretary shall develop programs with educational institutions and operators designed to enable persons to qualify for positions in the administration of this Act. In selecting persons and training and retraining persons to carry out the provisions of this Act, the Secretary shall work with appropriate educational institutions, operators, and representatives of miners in developing and maintaining adequate programs for the training and continuing education of persons, particularly inspectors, and where appropriate, the Secretary shall cooperate with such institutions in carrying out the provisions of this section by providing financial and technical assistance to such institutions.

Ante, p. 83.
5 USC 3101
note.

EFFECT ON STATE LAWS

SEC. 506. (a) No State law in effect on the date of enactment of this Act or which may become effective thereafter shall be superseded by any provision of this Act or order issued or any mandatory health or safety standard, except insofar as such State law is in conflict with this Act or with any order issued or any mandatory health or safety standard.

(b) The provisions of any State law or regulation in effect upon the operative date of this Act, or which may become effective thereafter, which provide for more stringent health and safety standards applicable to coal mines than do the provisions of this Act or any order issued or any mandatory health or safety standard shall not thereby be construed or held to be in conflict with this Act. The provisions of any State law or regulation in effect on the date of enactment of this Act, or which may become effective thereafter, which provide for health and safety standards applicable to coal mines for which no provision is contained in this Act or in any order issued or any mandatory health or safety standard, shall not be held to be in conflict with this Act.

ADMINISTRATIVE PROCEDURES

SEC. 507. Except as otherwise provided in this Act, the provisions of sections 551-559 and sections 701-706 of title 5 of the United States Code shall not apply to the making of any order, notice, or decision made pursuant to this Act, or to any proceeding for the review thereof.

80 Stat. 381,
392.

REGULATIONS

SEC. 508. The Secretary, the Secretary of Health, Education, and Welfare, and the Panel are authorized to issue such regulations as each deems appropriate to carry out any provision of this Act.

OPERATIVE DATE AND REPEAL

SEC. 509. Except to the extent an earlier date is specifically provided in this Act, the provisions of titles I and III of this Act shall become operative ninety days after the date of enactment of this Act, and the provisions of title II of this Act shall become operative six months after the date of enactment of this Act. The provisions of the Federal Coal Mine Safety Act, as amended, are repealed on the operative date of titles I and III of this Act, except that such provisions shall continue to apply to any order, notice, decision, or finding issued under that Act prior to such operative date and to any proceedings related to such order, notice, decision or findings. All other provisions of this Act shall be effective on the date of enactment of this Act.

Repeal.
55 Stat. 177.
30 USC 451
note.

SEPARABILITY

SEC. 510. If any provision of this Act, or the application of such provision to any person or circumstance shall be held invalid, the remainder of this Act, or the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

REPORTS

SEC. 511. (a) Within one hundred and twenty days following the convening of each session of Congress the Secretary shall submit through the President to the Congress and to the Office of Science and Technology an annual report upon the subject matter of this Act, the

progress concerning the achievement of its purposes, the needs and requirements in the field of coal mine health and safety, the amount and status of each loan made pursuant to this Act, a description and the anticipated cost of each project and program he has undertaken under sections 301(b) and 501, and any other relevant information, including any recommendations he deems appropriate.

(b) Within one hundred and twenty days following the convening of each session of Congress, the Secretary of Health, Education, and Welfare shall submit through the President to the Congress and to the Office of Science and Technology an annual report upon the health matters covered by this Act, including the progress toward the achievement of the health purposes of this Act, the needs and requirements in the field of coal mine health, a description and the anticipated cost of each project and program he has undertaken under sections 301(b) and 501, and any other relevant information, including any recommendations he deems appropriate. The first such report shall include the recommendations of the Secretary of Health, Education, and Welfare as to necessary mandatory health standards, including his recommendations as to the maximum permissible individual exposure to miners from respirable dust during a shift.

SPECIAL REPORT

Federal and
State
coordination.

SEC. 512. (a) The Secretary shall make a study to determine the best manner to coordinate Federal and State activities in the field of coal mine health and safety so as to achieve (1) maximum health and safety protection for miners, (2) an avoidance of duplication of effort, (3) maximum effectiveness, (4) a reduction of delay to a minimum, and (5) most effective use of Federal inspectors.

(b) The Secretary shall make a report of the results of his study to the Congress as soon as practicable after the date of enactment of this Act.

JURISDICTION; LIMITATION

SEC. 513. In any proceeding in which the validity of any interim mandatory health or safety standard set forth in titles II and III of this Act is in issue, no justice, judge, or court of the United States shall issue any temporary restraining order or preliminary injunction restraining the enforcement of such standard pending a determination of such issue on its merits.

Approved December 30, 1969.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 91-563 accompanying H.R. 13950 (Comm. on Education & Labor) and No. 91-761 (Comm. of Conference).

SENATE REPORT NO. 91-411 (Comm. on Labor & Public Welfare).
CONGRESSIONAL RECORD, Vol. 115 (1969):

Sept. 25, 26, 29, 30, Oct. 1, 2: Considered and passed Senate.

Oct. 27-29: Considered and passed House, amended, in lieu of H.R. 13950.

Dec. 17: House agreed to conference report.

Dec. 18: Senate agreed to conference report.





Conference Report No. 91-761,
December 16, 1969 (To accompany S.
2917) --(Title IV -- Black Lung
Benefits)

TITLE IV—BLACK LUNG BENEFITS

PART A

The Senate bill set forth certain findings relative to the need for, and desirability of, a benefit program for inactive miners, their dependents, and their surviving widows and children where such miners are disabled or died due to complicated pneumoconiosis. It also provided that it is the purpose of title V of the Senate bill to provide interim emergency health benefits to coal miners who are totally disabled and unable to be gainfully employed due to complicated pneumoconiosis, to widows and children of such miners, and to develop further information on the subject. The House amendment did not have such a statement of purpose. The conference substitute finds that there are a significant number of living coal miners who are totally disabled from pneumoconiosis arising out of employment in one or more underground coal mines; that there are survivors of such miners whose death was due to this disease, and that few States provide such benefits. It also states that it is the purpose of this title to provide such benefits and to insure that future adequate benefits are provided to coal miners and their dependents where disability or death occurs from such disease.

The House amendment defined the terms coal mine, complicated pneumoconiosis, dependent, and widow. The Senate bill had no similar provision. The conference agreement adopts the House language for widows and dependents. It also defines the terms pneumoconiosis, secretary, miner, and total disability.

PART B

The Senate bill directed the Secretary of Health, Education, and Welfare to develop and promulgate disability benefits standards which would govern the determination of persons eligible to receive benefits and the procedure used in disbursing such benefits. The standards, among other things, are to take into consideration the length of employment in coal mines deemed sufficient to establish a claim. The standards are effective upon promulgation unless a later date of no more than 7 months after enactment is prescribed. The House amendment had no similar provision but defined the term complicated pneumoconiosis. The conference agreement directs the Secretary of Health, Education, and Welfare to prescribe by regulation, standards to determine whether a miner is totally disabled due to, or died from, pneumoconiosis. It provides that the regulations shall not be more restrictive than the regulations applicable to section 223(d) of the Social Security Act. It is expected that initially the criteria applied by the Secretary will be that now applied under section 223(d) of that act. Such standards would, among other things, require that the administrators of this program apply the best medical means available for ascertaining the disease in the miner.

The Senate bill provided for benefit payments to persons determined to be eligible by a State in accordance with the standards of the Secretary of Health, Education, and Welfare based upon the minimum monthly payment to which a Federal employee in grade GS-2, who is totally disabled is entitled. Under the Senate bill, the Secretary of Health, Education, and Welfare would make grants to cover the entire cost of such payments through June 30, 1971, and to pay one-half of such costs during the fiscal years ending June 30, 1972 and 1973. It authorized annual appropriations for those 3 fiscal years with a requirement for a proportionate reduction in grants and payments if appropriations are not sufficient.

The House amendment provided payments to miners totally disabled from complicated pneumoconiosis and to the widows of miners who suffered from complicated pneumoconiosis at the time of death. The disease must have arisen out of, or in the course of, the individual's employment in a coal mine. If he was so employed for 10 years or more, there is a rebuttable presumption that the disease so arose; if he was not, the individual must demonstrate that his disease so arose. Anyone who suffered from this disease is deemed to be totally disabled and therefore eligible.

Under the House amendment, payments are based upon the minimum monthly payment to which a Federal employee in grade GS-2, who is totally disabled, is entitled at the time of payment under provisions of Federal law relating to Federal employees (sec. 8112, title 5, United States Code). In the case of total disability, the disabled individual is entitled to payment at a rate equal to 50 percent of such minimum monthly amount. The widow of a miner entitled to payment would be eligible to receive the same amount. The payment would be increased to allow for up to three dependents. The first dependent would increase the basic payment by 50 percent; the second dependent by 75 percent; and the third dependent by 100 percent. The maximum monthly payment, therefore, to which an eligible individual is entitled under this subsection is equal to the minimum monthly payment such Federal employee is entitled to.

Under the House amendment, the Secretary of Labor shall enter into agreements with the Governors of the States under which the State will receive and adjudicate claims under this subsection from its residents and under which the payments will be made. Each Governor will implement the agreement in any manner he determines will best effectuate the provisions of this subsection. If the Secretary of Labor is unable to enter into an agreement with a Governor or if a Governor requests him to do so the Secretary may make payments directly. When the Secretary of Labor has an agreement with a State he will make a grant to the State for the purpose of making the individual payments.

No claim would be considered unless it is filed (1) within 1 year after the date an employed miner received the results of his first chest roentgenogram as provided under section 203, or, if he did not receive such a chest roentgenogram, the date he was first afforded an opportunity to do so under that section, or (2) in the case of any other claimant, within 3 years from the date of enactment of this act, or, in the case of a claimant who is a widow, within 1 year after the death of her husband or within 3 years from the date of enactment of this act, whichever is the later.

The conference substitute provides that the program under part B would be administered by the Secretary of Health, Education, and Welfare who, based on the heretofore mentioned standards, shall provide benefit payments to miners for total disability from pneumoconiosis and to widows of miners whose death is due to this disease. If a miner who suffered or is suffering from the disease was or is employed in one or more underground coal mines for 10 or more years, there is a rebuttable presumption that his disease arose out of such employment and if a deceased miner was so employed and died from a respirable disease, there is also a rebuttable presumption that death was due to this disease. If a miner is suffering or suffered from a chronic dust disease of the lung based on certain specified medical evidence as defined in section 411(c) (3), there is an irrebuttable presumption that he is totally disabled due to pneumoconiosis or that his death was due to this disease. The benefit payments are to be made as provided in the House amendment; that is, in accordance with the minimum monthly payment to which a Federal employee in grade GS-2 is entitled for total disability. Benefits for miners are to be reduced by an amount equal to any payment which the miner or his widow receives under State workmen's compensation, unemployment compensation, or disability insurance laws due to disability of such miner, and the amount by which such payment to the miner would be reduced on account of excess earnings under the social security laws.

In the case of total disability of a miner, the claims must be filed on or before December 31, 1972. In the case of a widow, the claim must be filed within 6 months after death of her husband or by December 31, 1972, whichever is later. Benefits are payable to a widow due to death of a miner under part B if the miner was receiving total disability benefits prior to his death or if the death of the miner occurred prior to January 1, 1973. Also, the benefit program provides that no benefits shall be paid after December 31, 1972, for a miner who filed his claim after December 31, 1971. The House amendment provided that no benefit payments shall be made to residents of any State which, after enactment, reduces to persons eligible under this program the benefits it pays under its State laws which are applicable to its general work force with regard to workmen's compensation, unemployment compensation, and disability insurance, and which are funded by employer contributions. Benefit payments made under State programs funded by general revenues are not included in the maintenance of effort provision in the House amendment for the reason that they are not considered to be workmen's compensation, unemployment compensation, or disability insurance programs as such programs are generally understood, and as they are intended to be understood within the context of this benefit program. Any changes in such payments or programs subsequent to the date of enactment, therefore, would not affect payments to the residents of such State under the House amendment. The Senate bill prohibited the making of benefit payments where a State reduced its benefits to an eligible person. The conference substitute adopts the House amendment without change and together with the above intent.

PART C

The conference substitute also provides that on or after January 1, 1973, benefit claims must be filed pursuant to applicable State workmen's compensation laws, except, in any period when miners or widows are not covered by any such law which provides adequate coverage for pneumoconiosis, they shall be entitled to claim benefits under this provision of the act. A State workmen's compensation law shall not be deemed to provide adequate coverage for pneumoconiosis during any period unless it is included in a list of State laws found by the Secretary of Labor and published by him, in accordance with guidelines set forth in this provision, to be adequate. During any period after December 31, 1972, in which a State workmen's compensation law is not so included, the applicable provisions of the act of March 4, 1927, as amended, shall be applicable to an operator of an underground coal mine in such State with respect to death or disability due to this disease arising out of employment in such mine. During such period, the operator shall be liable for, and secure the payment of, benefits to the persons listed in section 412(a) as provided in part C of this title, except that no benefit payments shall be required for any such period seven years after enactment.

Report of the Committee on
Ways and Means on H. R. 16311,
Family Assistance Act of 1970,
House of Representatives Report
No. 91-904

FAMILY ASSISTANCE ACT OF 1970

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 16311

TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE A BASIC LEVEL OF FINANCIAL ASSISTANCE THROUGHOUT THE NATION TO NEEDY FAMILIES WITH CHILDREN, TO PROVIDE INCENTIVES FOR EMPLOYMENT AND TRAINING OF MEMBERS OF SUCH FAMILIES, TO IMPROVE THE ADULT ASSISTANCE PROGRAMS, TO MAKE OTHER CHANGES TO IMPROVE THE PUBLIC ASSISTANCE PROGRAMS, AND FOR OTHER PURPOSES



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FAMILY ASSISTANCE ACT OF 1970

MARCH 11, 1970.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLS, from the Committee on Ways and Means,
submitted the following

REPORT together with ADDITIONAL AND DISSENTING VIEWS

[To accompany H.R. 16311]

The Committee on Ways and Means, to whom was referred the bill (H.R. 16311) to amend the Social Security Act to provide a basic level of financial assistance throughout the Nation to needy families with children, to provide incentives for employment and training of members of such families, to improve the adult assistance programs, and to make other changes to improve the public assistance programs, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. PRINCIPAL PURPOSES AND SCOPE OF THE BILL

President Nixon, in transmitting his recommendations on welfare reform to the Congress in October of 1969, declared—

The present welfare system has failed us—it has fostered family breakup, has provided very little help in many States and has even deepened dependency by all too often making it more attractive to go on welfare than to go to work.

I propose a new approach that will make it more attractive to go to work than to go on welfare, and will establish a nationwide minimum payment to dependent families with children.

The President listed the following effects of his proposal:

For the first time, all dependent families with children in America, regardless of where they live, would be assured of minimum standard payments based upon uniform and single eligibility standards.

For the first time, the more than 2 million families who make up the "working poor" would be helped toward self-sufficiency and away from future welfare dependency.

For the first time, training and work opportunity with effective incentives would be given millions of families who would otherwise be locked into a welfare system for generations.

For the first time, the Federal Government would make a strong contribution toward relieving the financial burden of welfare payments from State governments.

For the first time, every dependent family in America would be encouraged to stay together, free from economic pressure to split apart.

The provisions of H.R. 16311, as reported by your committee are, with certain exceptions described in this report, essentially patterned after the proposals of the President.

The bill is intended to convert the existing program from one which results in people remaining in dependency to one which will encourage people to become independent and self-supporting through incentives to take training and enter employment.

Your committee's bill would make major improvements and reforms in the provisions of the Social Security Act relating to the programs which aid needy families with children, including coverage of the working poor; the programs which aid the aged, blind, and disabled; and the programs which provide manpower services, training, employment, and child care to welfare recipients.

FAMILY ASSISTANCE

First, the bill would make basic reforms in the program which furnishes assistance to needy families with children, remove inequities in treatment of the working poor and the nonworking poor, emphasize work incentives and work requirements, and improve and simplify administration of such public assistance, by providing—

(1) A new basic Federal family assistance plan, with federally assisted State supplementation, for poor families with children in place of the present program of aid to families with dependent children, but including for the first time coverage of poor families regardless of the work status of the father (the States would not be required to supplement payments to the working poor);

(2) Requirements that, as a prerequisite to receipt of benefits, every adult in the assisted families (including the adult already working) register at the employment office for work or training (except mothers with preschool children and persons who are ill or of advanced age), or sign up for vocational rehabilitation if handicapped.

(3) Uniform, nation-wide, eligibility requirements and payment procedures, both for the basic Federal family assistance plan and the State supplementary payments;

(4) Incentives for the States to make agreements with the Federal Government to administer supplementary payments programs; and

(5) New provisions holding deserting parents responsible for Federal payments made to their families under the family assistance or State supplementary plans.

WORK AND TRAINING

Second, the bill improves the program of employment and training services and of other services (including child care) needed by recipients who are registered at employment offices by providing—

(1) A new program of manpower, training, and employment services to be administered by the Secretary of Labor through the State employment offices;

(2) A Federal program of full-cost grants and contracts for child care services to enable mothers who are required to register for training and employment (as well as those who register on a voluntary basis) to participate in work or training;

(3) A new system of providing services to support training or employment through agreements between the Federal Government and the States; and

(4) A more equitable, uniform, and effective system of incentive allowances and reimbursement of work expenses.

ADULT ASSISTANCE

Third, the bill would substantially improve the effectiveness of the adult assistance programs under the Social Security Act by providing—

(1) For combining the present categories for assistance to the aged, blind and disabled into one combined adult assistance program and for uniform requirements for such eligibility factors as the level and type of resources allowed and degree of disability or blindness;

(2) That the States assure that each aged, blind, or disabled adult will receive assistance sufficient to bring his total income up to \$110 a month;

(3) Incentives for the States to enter into agreements for Federal administration of the combined program; and

(4) A simplified Federal matching formula which will result in generally more favorable Federal participation in the cost of the payments.

II. SUMMARY OF PRINCIPAL PROVISIONS

FAMILY ASSISTANCE PLAN

ELIGIBILITY FOR AND AMOUNT OF PAYMENTS

Each family with children whose nonexcludable income (for definition of excluded income see below) is less than the family benefit level—computed as \$500 each for the first two members of the family and \$300 for each additional member—would be eligible for a payment under the family assistance plan after meeting the registration for work or training and other requirements. The amount of the benefit would be the difference between these amounts and the non-excluded income. For example, a family of four with no income would be eligible for a family assistance payment of \$1,600. Every needy family, both those now eligible under aid for families with dependent children (including those in families with unemployed fathers who are not

covered because they are in a State which has not exercised the option to cover this group) and those not eligible because the father is working (the working poor) would be eligible.

In determining income for the purpose of establishing eligibility for and the amount of the family assistance payment, the following types and amounts of income would be excluded:

- (1) All earnings of a child if regularly attending school;
- (2) Infrequently or irregularly received amounts of earned or unearned income, but not more than \$30 a quarter for each type;
- (3) Earnings needed to pay for necessary child care;
- (4) All earned income of adult members of the family at the rate of \$720 per year plus one-half of the remainder;
- (5) Food stamps and other public or private charity (not including veterans' pensions);
- (6) The training allowance for those in training;
- (7) The tuition part of scholarships and fellowships; and
- (8) Homegrown and used produce.

A family with more than \$1,500 in resources, other than the home, household goods, personal effects and property essential to the family's means of self-support would not be eligible for family assistance payments.

Eligibility would be computed on a quarterly basis; payments would generally be made on a monthly basis.

Parents who desert or abandon their families would be liable to the Federal Government for any Federal payments to their families under the family assistance plan and the Federal portion of the State supplementary payments (described later) or for the amount of a court support order if less. Such sums are to be collected directly or by withholding them from payments due the parents under any Federal program.

DEFINITIONS OF FAMILY AND CHILD

An eligible family must consist of two or more persons (related by blood, marriage, or adoption), living together in the United States, at least one of whom is a child who is not married to another family member and who is in the care of or dependent upon another member of the family. Appropriate State law would be applied in determining relationships. A parent or spouse of a parent who is temporarily absent from the place of residence, seeking or engaging in employment (including military service), would be considered as living in the place of residence. A "child" is an individual who is under age 18, or a full-time student under age 21.

REGISTRATION WITH PUBLIC EMPLOYMENT SERVICE

Each member of a family would be required to register for employment or training with a public employment office unless he or she is—

- (1) unable to engage in work or training because of illness, disability, or age;
- (2) a mother caring for a child under 6;
- (3) the mother in cases in which the father registers;
- (4) caring for an ill member of the household; or
- (5) a child under 16 or under 21 if in school.

Any person who falls into one of these exempt categories could voluntarily register at the employment office.

Those who are unable to participate in work or training because of disability would be referred for vocational rehabilitation services.

The Secretary of Health, Education, and Welfare is required to provide (for as long as he deems appropriate) child care services where an individual is registered and participating in training and employment.

If an individual required to register refuses to do so without good cause, or refuses vocational rehabilitation services without good cause, he would not be taken into account (but his income would be counted) in determining the family benefit. In such a case, the family benefit may be paid to a person outside the family under a protective payment arrangement.

STATE SUPPLEMENTATION OF FAMILY ASSISTANCE PAYMENT

REQUIREMENTS FOR STATE SUPPLEMENTATION

Each State whose AFDC payment level in January 1970 is higher than the family assistance level must agree to supplement the family assistance payment (under the conditions specified in the bill) up to that level (except where otherwise provided by the bill) or up to the poverty level if that is lower, in order to be eligible for Federal funds under Medicaid and other welfare programs. Federal matching would be available, except for the working poor, at a rate of 30 percent. The matching maximum would be the poverty level now in effect, but brought up to date annually by the Secretary of Health, Education, and Welfare to reflect increased living costs.

The States would not have to supplement payments to the working poor. However, in addition to being required to supplement cases which would be eligible under their present programs as in effect in January 1970 the States would have to supplement those cases which would be eligible if the program had the same resources limitations as the family assistance plan (\$1,500 except for home, household goods, and personal effects), the same definition of family and child, and the same excludable income provisions (other than those which disregard proportions of earned income). The States also would be required to supplement the incomes of families where the father is unemployed (which is now on an optional basis), or where the child is between age 18 and 21 and regularly attending school (now also on an optional basis).

AMOUNT OF SUPPLEMENTARY PAYMENTS

The States would be required to follow the rules that apply under the family assistance plan in computing payments except that special rules would apply in disregarding earned income for purposes of the supplementary payments.

The States would have to exclude the first \$720 a year (\$60 a month) of earned income, plus (1) one-third of the earnings between \$720 and twice the amount of the family assistance payment which would be payable if the family had no income, plus (2) one-fifth of any earnings above that amount. The effect of the combined earnings exemptions under the State supplementation and under the family assistance plan is roughly the equivalent of present law which provides for

excluding work expenses and disregarding the first \$30 of monthly earnings plus one-third of earnings over that amount. For example, if the adults in a family of four had \$1,200 in annual earned income the basic \$1,600 family assistance payment would be reduced by one-half of the \$480 remaining after \$720 is deducted from \$1,200. Thus, the family assistance payment would be reduced to \$1,360 (\$1,600—\$240). If the family lived in a State where the State payment (to a family of four with no income) in January 1970 was \$2,400, the required States supplement payment would be figured as follows:

The family assistance payment—\$1,360—plus the earned income not disregarded—two-thirds of the \$480, or \$320—is subtracted from the \$2,400 figure. This results in a supplementary payment of \$720. The total income of such a family would consist of \$1,320 in family assistance payment, \$720 in the State supplementary payment and \$1,200 in earnings, for a total annual income of \$3,280.

ADMINISTRATION

ADMINISTRATIVE ARRANGEMENTS

The bill provides for three alternative administrative arrangements. First, the Secretary of Health, Education, and Welfare could make an arrangement with a State for the Federal Government to administer both the family assistance plan and the State supplementary program. Under this arrangement the Federal Government would pay all administrative costs. Second, the Secretary could make an agreement with a State under which the State would administer the family assistance payments and State supplementary payments. Third, if the Secretary makes no agreement with a State the State will administer the supplementary payments and the Federal Government will administer the family assistance payments. Under the second and third arrangements, the Federal Government would pay all the cost of administering the family assistance plan and the Federal Government and the States would share equally in the administrative costs of making the State supplementary payments.

APPEALS PROCEDURE

Persons who disagree with determinations relating to eligibility for or amounts of family assistance plan payments may obtain a hearing. For persons on the rolls payments would continue until there is a decision based on the hearing, which must be rendered within 90 days of a request for hearing. If the decision based on the hearing is adverse, the money paid out in the interim by the Federal Government would have to be returned. Final determinations are to be subject to judicial review in Federal district courts but the Secretary's decisions as to any fact would be conclusive and not subject to review by the court.

SPECIAL PROVISIONS FOR PUERTO RICO, GUAM, AND THE VIRGIN ISLANDS

The family assistance plan applies to Puerto Rico, Guam, and the Virgin Islands, but all of the dollar figures in both the family assistance plan and the revised program of aid to the aged, blind, and disabled (except for the \$720 of earnings disregarded under the family assistance

plan) program are to be modified (but only downward) by the same proportion that the per capita income of each bears to the per capita income of the lowest per capita-income State.

WORK AND TRAINING PROGRAMS

EXISTING PROGRAM REPEALED

The existing work incentive program (which went into effect in all the States on July 1, 1969) would be repealed and a new program would be established to take its place.

OPERATION OF PROGRAM

The Secretary of Labor would, under his own priorities for the selection of participants, assure the development of an employability plan for each individual registered with the employment office under the program. The training and employment potentials of the working poor who are registered will be closely examined toward the end of lessening, or completely eliminating, their dependency on cash benefits under the program. Mothers with pre-school children who volunteer would be given the same consideration for participation as those who are referred on a mandatory basis.

The individuals would then receive the services and training called for under the plan (including grants to relocate a family to find employment). The training and services would be similar to those currently provided under the WIN program, including special work projects for the performance of work in the public interest through contracts with governmental agencies and nonprofit organizations. The Secretary of Labor would be required to use other manpower programs to the maximum extent feasible. The State welfare departments would be required to provide health and other supportive services to facilitate the participation of individuals in the training program.

Appropriations are authorized to meet up to 90 percent of the cost of the training program. The non-Federal contribution could be made in cash or in kind. If the required non-Federal matching of 10 percent was not met in any State, a portion of its Federal share of medicaid and other welfare program expenditures would be withheld until the deficit was made up. Authorization is also made for advance funding. The Secretary of Health, Education, and Welfare may transfer to the Secretary of Labor the amount of money that family assistance recipients would have received if they were not being paid wages under a Labor Department on-the-job training program. These funds are to be available to support such programs.

TRAINING ALLOWANCES

Each person participating in the training program would receive an allowance of \$30 a month. Larger incentive payments may be available for participants in institutional programs where MDTA allowances are payable. The Secretary of Labor would also provide allowances to cover the transportation and other costs directly associated with the training.

REFUSAL TO ACCEPT TRAINING OR EMPLOYMENT

An individual who, without good cause, refuses to accept suitable training or employment would receive the same treatment as a person who refuses to register.

CHILD CARE

The Secretary of Health, Education, and Welfare both directly (by contract or grant to public or private agencies) and through a system of prime grantees is required to provide necessary child care services for individuals participating in training or employment under the manpower program. The Secretary is authorized to make grants for up to 100 percent of the costs of child care projects to public or non-profit private agencies which, in a particular geographic area, will assure that day care is provided to manpower training participants. Such prime grantees would be designated by the appropriate elected or appointed official or officials in such area and would have to demonstrate a capacity to work effectively with the manpower agency. Where appropriate, group or institutional care for children attending school would be provided through arrangements with a local educational agency. Child care would be provided in the light of the different circumstances and needs of the children involved, and where a family is able to pay for care the Secretary could charge a fee reasonably related to that ability. Appropriations (no dollar amount specified) and advance funding are authorized.

EVALUATION AND ANNUAL REPORT

The Secretaries of Labor and Health, Education, and Welfare would be required to provide continual evaluation of the manpower and employment program. The Secretary of Labor may contract for independent evaluation, and he may establish a data collection, processing, and retrieval system. The Secretary of Labor would file an annual report with the Congress on the operation of the training program, and the Secretary of Health, Education, and Welfare would report similarly on the child care and supportive services provided under the bill. The first of such reports would be due on or before September 1, 1972. An authorization of \$15 million a year is provided for research and evaluation activities relating to work and training.

SOCIAL SERVICES FOR FAMILIES WITH DEPENDENT CHILDREN

The present program of aid to families with dependent children would be changed by removing all cash assistance provisions. The provisions of present law under which the costs of social services, certain foster care, and emergency assistance are subject to 50-75 percent Federal matching would be retained.

AID TO THE AGED, BLIND, AND DISABLED

FEDERAL STANDARDS AND REQUIREMENTS

The present provisions for programs for aid to the needy aged, blind, and disabled are repealed and a new combined Federal-State program is established to cover essentially the same people.

Under the new program, the States could not have (1) any duration of residence requirement, (2) any citizenship requirement which includes any U.S. citizen, or (3) a requirement which would exclude aliens lawfully admitted for permanent residence who have resided in the United States continuously for 5 years immediately prior to application, or (4) relative responsibility provisions other than for spouses or parents of recipients.

The States would be required to (1) provide a payment sufficient to bring an individual's total income up to at least \$110 a month, or, if higher, the standard in effect on the date of enactment, (2) follow the Secretary's definitions of blindness and disability, (3) make applicable to the disabled the mandatory disregard of the first \$85 a month of earned income plus one-half of the remainder, now applicable to the blind, (4) make applicable to the aged on an optional basis the same earnings exemption (\$60 a month plus one-half of additional earnings) applicable to the family assistance plan, and (5) use the Federal definition of allowable resources applicable to the family assistance plan (\$1,500 plus home, personal effects, and income-producing property essential to the person's support). The provision in the Social Security Amendments of 1969 requiring the States to pass along to adult assistance recipients \$4 of the social security benefit increase, which as enacted applies only to the months of April, May, and June 1970, would be continued indefinitely.

FEDERAL MATCHING PROVISIONS

The Federal Government would pay 90 percent of the first \$65 of average payments made to eligible adult assistance recipients, and 25 percent of the remainder up to a limit to be set by the Secretary. The Federal Government would also pay 50 percent of the administrative costs of the adult programs.

ADMINISTRATION

The States could continue to administer the adult programs, or the Secretary could enter into an agreement with a State under which the Federal Government would perform all or some of the functions involved in making payments under the program. In the latter case, the Federal Government would pay all administrative costs.

EFFECTIVE DATE

The provisions of the bill (except for authorization for money to support child care projects which would be effective upon enactment) would be effective on July 1, 1971, with special provisions for States with statutes that would prevent them from complying with the bill at that time.

III. GENERAL DISCUSSION OF THE BILL

A. ESTABLISHMENT OF A PLAN FOR ASSISTANCE TO FAMILIES WITH CHILDREN

Your committee is very concerned about the rapid growth in the number, as well as the increase in the proportion, of children receiving aid under AFDC programs. Since 1960, the number of recipients has

increased from 2.4 million to about 6.7 million. Moreover, the proportion of children receiving assistance has been rapidly increasing—from 30 children per 1,000 in 1955 to about 60 children per 1,000 in 1970. In addition the costs of these programs have more than tripled during the last 10 years (to about \$4 billion at present) and, according to estimates by the Department of Health, Education, and Welfare, could more than double again during the next 5 years unless action is taken now to deal with the underlying causes of this crushing increase in both costs and numbers of recipients.

The major part of the increase has resulted from the added number of families who receive aid because the father is absent from the home. These cases, including those in which the father has abandoned his family and cases in which the mother is not married to the father, now make up over three-fourths of the families on the AFDC rolls.

Your committee made a number of modifications in the family assistance provisions of the bill proposed by the administration which are designed to halt the trends that have existed in the growth of the number of families on the AFDC rolls.

During its deliberations, the principal efforts of your committee were in the direction of strengthening the provisions of the legislation to assure the establishment of an effective work and training program, building upon the groundwork that has been laid in putting the existing work incentive program into operation. It is the clear intention of your committee, based upon assurances given by the Secretary of Health, Education, and Welfare and the Secretary of Labor, that the work and training program will provide a method of guaranteeing that all adult members of families receiving assistance under the family assistance plan will receive all available training and employment services and other supportive services, including child care, necessary to assist them in obtaining employment and ultimately attaining self-support.

Your committee wishes to emphasize its clear understanding that all adult family assistance recipients, except for those specifically exempted by the bill, must register for training or employment. Contrary to the administration's proposal, under the committee bill this requirement applies to the working poor as well as to those who are unemployed or working part time. The committee believes this is an essential difference and a material improvement in the bill. Under this modification the employment status of many of the working poor parents will be improved and upgraded.

Your committee also added to the bill provisions holding parents who abandon their families responsible for Federal assistance received by their families. This new approach plus greater emphasis by the Federal Government and the States in implementing the determination of paternity, the location of absent parents and the enforcement of support provisions of the 1967 Social Security Amendments should have some effect in reducing the growth of the assistance rolls.

Several times in the past your committee has attempted, within the framework of the existing AFDC programs, to provide measures through which families could be assisted in maintaining stability and achieving economic independence. In the course of the last decade, major legislation providing for a wide range of services to AFDC families and for strong emphasis on work and training for assistance recipients has been enacted. The legislation enacted in 1962 and 1967

attempted to reverse the increasing dependence of families on assistance. It has become obvious, however, that basic structural and administrative changes in the AFDC programs are necessary if the present trends of family instability and dependence on welfare are to be halted and reversed.

The major thrust of the bill is toward:

1. Equitable treatment of working poor families;
2. The reduction of variations in payment levels among the States through the introduction of a Federal floor for family assistance payments;
3. Assisting families in achieving economic independence through a national uniform requirement to register for employment and training and the establishment of a strengthened manpower training program.

The overall plan represents a new direction for family assistance and was designed to carry out the intent of your committee to reduce dependence on assistance and restore more families to employment and self-reliance, and thereby eventually reverse the present trend of spiraling cost and increasing dependence upon welfare.

1. THE FAMILY ASSISTANCE PLAN

a. Eligibility for and amount of family assistance payments

(1) *Eligibility.*—Each family with children under 18 (or under 21 if attending school) whose income (other than that excluded) is less than \$500 per year for each of the first two family members and \$300 per year for each additional family member, and whose resources (other than those excluded—the home, the household goods, personal effects, etc.) are less than \$1,500 would be eligible to receive a family assistance benefit.

Your committee believes that one inequity in the present AFDC program that should be remedied at this time is the exclusion of needy families where the father is in the home and fully employed. Your committee believes it is bad social policy to have families in like situations treated differently because of the employment status of the family head. The exclusion of families in which the father is working has acted as an incentive to fathers to become unemployed or leave home in order to qualify their families for assistance. The bill would, therefore, include working poor families under the program and provide a uniform earnings exemption which is equally applicable to families with male and female heads as well as those who are fully and partially employed. For purposes of Federal benefits under the family assistance plan, the first \$60 a month in earnings would be disregarded plus one-half of the remainder, so that it would be possible, for example, to have a family of four receiving some benefits under the program up until its income exceeds \$3,920.

Your committee's bill would eliminate two other situations of lack of equal treatment. At present, AFDC benefits are available to families with unemployed fathers in some States, but not in others. Second, unemployment has been defined by the Department of Health, Education, and Welfare as working for less than 30 hours a week, which may be an incentive for many families to restrict their work

activities. These two distinctions would be eliminated as to Federal benefits under the new program.

The committee agrees with the administration that it is essential that we do not perpetuate the situation where working people see little or no economic advantage in continuing in employment and drop out of the work force to become totally dependent on the welfare system.

(2) *Amount.*—The family assistance benefit would consist of \$500 per year for each of the first two family members, plus \$300 per year for each additional family member, and would be reduced by nonexcluded income. In any family there are certain common expenses in housing, utilities, fuel, etc., which must be met. Since the smallest family that will be covered is one consisting of two persons, your committee believes that it is logical that the amount provided for each of the first two members of the family be larger than the amounts provided for each additional member of the family.

These payment rates establish a Federal income maintenance floor which in most States will be increased by required State supplementation for all families except the working poor. In the eight States whose AFDC payments are now lower than the basic Federal floor, the bill provides an increase in the level of aid to needy families with children. The amount of payments may be lower in the case of individuals in Puerto Rico, the Virgin Islands, and Guam than in the States, but would be substantially higher than at present.

(3) *Period for determination of benefits.*—Your committee's bill provides that a family's eligibility for benefits, and the amount of its benefits would be determined for each calendar quarter on the basis of estimates of income for that quarter, made in the light of income received in previous quarters. The estimates could be modified in the light of changes in circumstances and conditions, and in accordance with regulations regarding applications filed late in a quarter, or in cases in which income and expenses in one period are to some extent attributed to another period. Provision is also made for rendering a family ineligible for benefits if its gross income from a trade or business is unduly large.

The bill would provide for use of a calendar-quarter accounting period rather than a shorter period, such as a month, or a longer period, such as a year. One important advantage of the quarterly accounting period is that it would facilitate verification of earnings through use of social security records, since social security earnings are reported on a quarterly basis. Records of monthly earnings are not available from either the Social Security Administration or the Internal Revenue Service.

Your committee's bill would allow the Secretary of Health, Education, and Welfare to prescribe by regulation the circumstances under which and extent to which a family's payments will be reduced because the application for payments was filed some time after the beginning of a quarter. Many potential applicants would not know that they would lose payments by not filing when they were first eligible, and in addition, there would be many reasons why an application could not be filed as soon as the need arose—e.g. the only adult member of the family could be ill, or unaware of possible help, with the result that he would fail to file as early in the calendar quarter as he should.

Your committee has concluded that, in some cases, in order to prevent inequity it would not be appropriate to count as income for a quarter all income received in that quarter, a part of which should properly be distributed to prior or subsequent quarters. For example a self-employed farmer often receives the bulk of his income in the fall when his crops are sold, and little or no income during the rest of the year. If such a person's income were counted in the quarter in which it is received, he could get no payments for that quarter. Conversely, the amount of income received in a single quarter might be sufficient to disqualify a family for any payments during the year. Your committee's bill provides, therefore, that, in determining eligibility and payment amounts, the Secretary of Health, Education, and Welfare may allocate income received in a given quarter to prior or subsequent quarters. In the case of self-employment income, your committee expects that the Secretary would ordinarily allocate the annual income evenly to each of the four quarters of the year, unless the nature and circumstances of the self-employment income were such as to make this allocation inappropriate. Payment amounts would be determined as though income were earned in the quarter to which the income is assigned.

(4) *Special limits on gross income.*—Your committee believes that the net earnings from farming and certain other businesses require special treatment. People in such businesses may have substantial gross incomes during a year but net earnings small enough to qualify themselves and their families for payments under the family assistance plan. The net earnings of a family whose income is derived from a business can fluctuate considerably from year to year. The net earnings may be high in one year and very low the next year. One reason for this is that a businessman has considerable control over the amount of his net earnings; he may choose the time to incur a number of business expenses in order to increase or decrease his net earnings in any given year.

Also the amount of net earnings depends to a large extent on business expenses, which are deductible for income tax purposes. Depreciation allowances and other income tax deductions, for example, reduce the net earnings of a businessman without actually reducing his spendable income.

In the opinion of your committee it would be inappropriate to permit people who have a large gross income to get family assistance payments when they have a substantial cash flow from which they live in moderate or better-than-moderate circumstances. For this reason, your committee's bill permits the Secretary of Health, Education, and Welfare to consider ineligible a family that has substantial gross income from a trade or business.

b. Income

(1) Meaning of income.—

Earned income is defined as remuneration from employment and net earnings from self-employment. Earned income from employment excludes certain items that are also excluded from covered wages under old-age, survivors, and disability insurance.

Net earnings from self-employment are defined in the bill by reference to the present definition applicable to old-age, survivors, and disability insurance, with the exception of certain provisions of the old-age, survivors, and disability insurance definition which your

committee believes inappropriate for the family assistance plan, such as the special provision under which a farmer's net income may be presumed to be a given percent of his gross income.

Under your committee's bill, certain items are specifically included in unearned income in order to avoid the necessity of deciding close questions as to whether they are to be treated as earned or unearned. Thus, annuities (which frequently result from past earnings) are counted as unearned income, as are prizes and the proceeds of life insurance.

(2) *Exclusions from income.*—

(a) *Student income.*—Your committee's bill would provide, subject to limitations prescribed by the Secretary of Health, Education, and Welfare, for exclusion of the earned income of a child who is regularly attending school. Existing law, in addition to excluding the earned income of a child who is a full-time student, also excludes the earned income of a part-time student with a less than full-time job.

Your committee continues to believe that special treatment of earnings of students is warranted so that these earnings may help to finance school attendance and offer tangible rewards that encourage work habits. The purpose of authorizing the Secretary to prescribe limitations on the earned income of a student that may be excluded is to make allowance for the fact that a few students may have exceptionally large earned incomes, at least some of which should go to reduce the family benefit.

(b) *Irregular income of \$30 or less a quarter.*—In determining income under the family assistance plan, the Secretary is authorized to exclude unearned income of \$30 or less a quarter and in addition earned income of \$30 or less a quarter, provided that such earned and unearned income is received infrequently or irregularly. Your committee believes that the provision for exempting such income would facilitate administration since it would be possible to ignore very small amounts of income irregularly or infrequently received. A small cash gift, for example, could be excluded. Similarly, earnings within the \$30 quarterly limits from occasional work, such as babysitting, performed on an irregular or infrequent basis, could be excluded.

(c) *Child care expenses.*—Your committee's bill would provide for the exclusion of an amount of earned income of a family equal to all or part (according to a schedule prescribed by the Secretary) of the cost of child care which was necessary for securing or continuing manpower training, vocational rehabilitation, or employment. Your committee believes that, since child care is frequently costly, failure to exclude the cost of this care from income in determining the amount of the family assistance payment might well create a disincentive, if not a total barrier, to employment on the part of some mothers. Under other provisions in the bill the Secretary of Health, Education, and Welfare is required to assure that child care is available for mothers who are in training.

(d) *First \$720 of earnings a year plus one-half of the remainder.*—Under present AFDC programs, a State is required to disregard student income, necessary expenses of employment, and the first \$30 a month of the total of the family's earned income plus one-third of the remainder of such income. (In addition, a State may, but is not required to, disregard not more than \$5 per month of additional

income.) Your committee's bill provides for removing the present provisions and provides instead for exempting the first \$720 per year (or proportionately smaller amounts for shorter periods) of earned income of the family in determining the amount of the family assistance payment. This exclusion is intended to take account of work-related expenses and to avoid any disincentive to employment that such expenses—for example, the cost of transportation, lunches, and employment taxes—might otherwise create. The bill would also exclude one-half of the family's earned income above the exempt amount. (As indicated above the earned income of a student would generally be excluded entirely). Your committee believes that this treatment of earned income would set a uniform standard and provide a strong incentive both to take employment or to increase employment activity.

(e) *Other aid based on need.*—Your committee's bill would provide that food stamps and other assistance (not including veterans' pensions) provided on a basis of need by a public or private agency would have no effect on the amount of the family assistance payment. Your committee believes that any other policy would tend to have a circular effect and would render the food stamps or other assistance largely meaningless. (See p. 30 for further discussion of the correlation of family assistance payments and food stamps.) Veterans' pensions based on a test of income, though, would be included in determining a family's income under the family assistance plan. Your committee believes that it is preferable to keep the long-established veterans' pension program intact by requiring that family assistance benefits be reduced dollar for dollar by the amount of any veterans' pension received by a family member.

(f) *Training allowances.*—The bill would exclude from income the allowances provided by the Secretary of Labor to individuals undergoing training. If the family assistance benefits were reduced on account of receipt of these allowances, their purpose, which is to provide an incentive for training, would be largely nullified. Training incentive allowances for individuals undergoing vocational rehabilitation are intended to be excluded.

(g) *Scholarships and fellowships.*—The bill would exclude from consideration as income any portion of a scholarship or fellowship received for use in paying the costs of tuition and fees at any educational institution. Any portion of such payments which are used for general living expenses, however, would be included as unearned income. Your committee believes that if the portions of any scholarship or fellowship which are earmarked for costs to the educational institution were treated as family income, the objective of the scholarship or grant might well be defeated.

(h) *Home produce.*—The bill would provide for the exclusion of home produce of a family used by the household for its own consumption. This provision is necessary to avoid the administrative difficulties in evaluating the value of such home produce, and is consistent with the results of studies which indicate that there is generally very little net financial gain from home produce consumed at home.

c. Resources

(1) *Exclusions from resources.*—Under present law there is a wide variation in the manner in which resources, such as a person's home, are treated by the State public assistance programs. Many States

exclude the home as a resource while others consider the home only if its value exceeds a specified amount. Household goods, and personal effects are generally excluded under present programs. Your committee believes that a family's home, household goods, and personal property, as well as other property which is essential to a family's means of self-support, should not be considered resources and the bill so provides. Since one of the purposes of the bill is to help families take their place as productive members of society, it seems appropriate to remove disincentives to homeownership and to the accumulation of other reasonable personal effects. The exclusion of resources essential to a family's means of self-support, such as an automobile needed for purposes of employment, the tools of a tradesman, or the machinery of a farmer, is, of course, also important from the standpoint of the objective of strengthening the family's capacity for self-support.

(2) *Disposition of resources.*—Under the bill, other types of property would be subject to a \$1,500 limitation. Families with resources which are readily negotiable, such as stocks or bonds, can generally dispose of such resources and should be expected to dispose of resources above the \$1,500 limitation before they are considered eligible for family assistance payments. Proceeds from the disposal of such resources would, of course, be expected to be used by the family for their support and would be counted as cash income, which would be considered in determining the family eligibility for assistance and the payment amount. The disposal of certain other types of assets, such as buildings or land, would often require some time. Your committee's bill, therefore, would authorize the Secretary of Health, Education, and Welfare to prescribe time limits governing the disposition of various kinds of property and to make conditional family assistance payments during the time allotted for the disposal of the property in question. Income received from the disposition of resources would be expected to be used to support the family and would be considered to have been received during the period when the family was receiving conditional family assistance payments, and the family would be obliged to repay overpayments made to it subject to the conditions set forth in the provisions of the bill governing overpayments.

d. Meaning of family and child

(1) *Composition of family.*—Numerous witnesses who appeared before your committee expressed their deep concern over the effects of the present AFDC program and stated that it is characterized by incentives to family breakup and by the inequitable exclusion from assistance of poor families in which the father is employed.

The definition of family in the bill would eliminate the eligibility requirements in existing law under which families with children are eligible for assistance only if the child is living with designated relatives and is dependent by reason of the death, continued absence, or incapacity of a parent or, on an optional basis with the States, the unemployment of a father. Under the bill, a father could remain with his family, and even if he were employed, he and his family could be eligible for benefits under the family assistance plan if the other eligibility conditions are met.

As indicated by the term "family assistance," the new program would be based upon the existence of a family unit. The presence of a

child in the household would be the key to eligibility. When a family meets the income and resources tests, payments under the plan would be made for all members who were related by blood, marriage, or adoption, as long as they were living in the same residence and as long as at least one family member was under age 18, or under 21 if regularly attending school.

The bill would require that at least one child not be married to another family member and also that this same child be in the care of or dependent upon another family member in order to qualify the family for benefits. This would avoid making payments to a family consisting only of a husband and wife where the wife is under age 18 or a student. It would also avoid payment of benefits in situations where, for example, two brothers were living together and attending college on scholarships with neither being dependent upon nor supported by the other.

Although generally family members must be living in the same place of residence in order to qualify as a family for benefit purposes, the bill provides that a parent of a child living in the family residence, or the spouse of such a parent, who is temporarily away from home for the purpose of engaging in or seeking employment (including military service) or self-employment, would nevertheless be considered to be living in the home where such child resides. Your committee believes that it is clearly reasonable to consider such an individual as a family member and to consider any income he may have as income to the family.

If such a provision were not included, temporary absence from the home could disqualify the parent as a family member, with the result that the absent individual's income would not automatically be considered income to the family. Moreover, if the absent parent were the only parent in the family, a child who is temporarily left with a non-relative by this parent while he is away working or seeking work would be ineligible for benefits until the parent returned.

(2) *Definition of child.*—The bill defines a child as an individual who is under age 18 or under age 21 and a full-time student. There is no substantive difference between this definition and the definition in existing law.

(3) *Determination of family relationships.*—Your committee's bill follows the most usual approach of programs that make payments based on relationship—namely, basing determinations of relationship on State law. Under public assistance, each State, of course, applies its own laws bearing on the determination of relationships. Determinations of relationships under the social security program and the veterans' programs also are based on applicable State laws (those governing marriage and adoption as well as State intestacy laws). Under your committee's bill, the Secretary of Health, Education, and Welfare would have the authority to determine which State's law would be governing in particular cases and the Secretary could decide whether the law of the State in which the child was born or the law of the State in which the parents were married was to be used in determining whether a child was the child of another family member. The Secretary would also have the authority to determine, for example, which of two laws of the same State would be most appropriate in determining the relationships in a particular family.

(4) *Income and resources of noncontributing adult.*—Your committee's bill would exclude from consideration, in determining eligibility for, and the amount of, benefits under the family assistance plan the income and resources of any individual which are not available to the rest of the family. An individual whose income and resources are not so available would not be considered a family member and the benefit amount payable to the family would be computed without counting him. However, this rule would not apply to parents (or their spouses) since their income and resources should ordinarily be available to the family and since the exclusion of their income or resources might easily lead to abuses of the system.

(5) *Recipients of aid to the aged, blind, and disabled.*—Your committee's bill continues the usual rule against payment of benefits under more than one of the Federal-State public assistance plans by excluding from benefits under the family assistance plan any individual who elects to receive aid under the title XVI plan (assistance for needy adults). (A similar prohibition in title XVI against duplication is continued from existing law.)

e. Payments and procedures

Under your committee's bill, payment would be made to one or more members of a qualified family, or to another interested person, at such times and in such installments as the Secretary determines. Appropriate adjustments in future payments, or recovery from or payment to the family, would be made to rectify overpayments and underpayments.

The Secretary would prescribe regulations regarding the filing of applications and supplying of data to determine eligibility of a family and the amounts for which the family is eligible. Beneficiaries would be required to report events or changes of circumstances affecting eligibility or the amount of benefits. When reports by beneficiaries are delayed too long or are too inaccurate, part or all of the resulting benefit payments could be treated as recoverable overpayments.

(1) *Payment of benefits.*—It is the intent of your committee that payments would ordinarily be made (after determination of eligibility and registration for manpower training, services, and employment) on a monthly basis to the head of the family. To take account of diverse family situations and to facilitate administration, however, a provision in the bill would allow the Secretary to make payments to other members of the family or to other interested persons, and also to make payments at such times and in such installments (e.g., semimonthly, quarterly, semiannually, or annually) as might be indicated by the circumstances. For example, a quarterly payment could be made to facilitate administration in situations where the family would, because of earnings, be eligible for only a small monthly payment.

To further facilitate administration, your committee's bill would permit establishment of ranges of income—that is, permit use of income brackets—within which a single benefit amount would apply.

(2) *Overpayments and underpayments.*—Your committee's bill would permit adjustments on account of overpayments or underpayments to be made by adjusting future benefits of the family or by recovery from any family member. The bill, however, would preclude recovery of overpayments where the family is without fault and re-

covery would either defeat the purpose of the family assistance plan or be against equity and good conscience or (because of the small amount involved) impede efficient or effective administration.

Your committee believes that, generally, determinations of "without, fault" would be made on an individual basis, and in determining whether an individual is without fault, the Secretary could be expected to consider an individual's age, education, and physical and mental condition. An individual would not be found to be without fault if an incorrect payment which was made to him or on his behalf resulted from his statement which he knew or should have known to be incorrect or from his failure to furnish information which he knew or should have known to be material, or from his acceptance of payment which he either knew or could have been expected to know was incorrect.

(3) *Hearings and review.*—Your committee's bill requires that there be notice and opportunity for hearings to any individual who disagrees with any determination with respect to eligibility for payments, the number of members of the family, or the amount of the payments. The individual would have to request the hearing within 30 days. Decisions would be rendered within 90 days following a properly submitted request, and although families already receiving assistance payments would continue to do so while their hearing is pending, such payments would be considered overpayments if the Secretary's initial determination were sustained. Final determination of the Secretary would be subject to judicial review in Federal district court; however, determinations as to the facts which the Secretary makes after a hearing provided by him would not be subject to review by the court.

(4) *Applications and furnishing of information by families.*—To enable the Secretary to obtain the information needed to determine eligibility or payment amount, your committee's bill would authorize the Secretary to require that individuals file applications, furnish evidence, and report events and changes that might affect eligibility or payment amounts. Since it would be necessary, to a substantial extent, to rely on information supplied by recipients, it seems important to your committee to encourage accurate and prompt reporting. Therefore, your committee's bill would authorize the Secretary to prescribe those situations where failure to report or the filing of delayed or inaccurate reports would result in the treatment of payments to the family as overpayments and subject to full recovery. It is the committee's intention that the Secretary provide for tight administration of the processing of claims under the program and that to the extent feasible methods adopted be as detailed and effective as those that have been utilized to substantiate applications under the old-age, survivors, and disability insurance program.

(5) *Furnishing of information by other agencies.*—In determining eligibility and the amount of payments under your committee's bill, the Secretary would verify the information on income and other information given by the claimant. Several Federal agencies have information that may be useful for this purpose. Information on certain benefits and payments could be obtained from the Social Security Administration and from other Federal agencies such as the Railroad Retirement Board and the Veterans' Administration. The Social Security Administration has direct access to information about earnings from employment and self-employment covered by social

security. If a recipient has income other than from earnings covered by social security, information from another source would be required in order to verify information given by the claimant. The Treasury Department would be able to furnish data from income tax returns. Your committee's bill would require the head of any Federal agency to provide information needed by the Secretary to verify information affecting eligibility or payment amount.

f. Registration and referral of family members for manpower services, training, and employment

Your committee believes that registration for work and training is a very essential part of the family assistance plan. While the present AFDC program contains a registration requirement, it has been implemented as was intended. This requirement is strengthened in the committee bill.

Present law has a general requirement that State welfare agencies refer those persons for registration whom they deem "appropriate," with several categories of persons specifically excluded. State agencies have taken varying attitudes toward who is appropriate for referral, with some taking an extremely restrictive approach and thus crippling the training effort.

Under the bill reported by your committee, the word "appropriate" is removed from the law, and only clearly specified groups are exempt from registration. This will strengthen the work requirement and at the same time provide for nationally uniform administration insuring that all persons appropriate for training and employment programs will be seen by the employment service offices.

Your committee believes that in the administration of the registration provisions, there should be enough flexibility to assure the efficient operation of the training and employment provisions of the bill. This means that short forms could be used for the initial registration. Employment service representatives should be stationed in the offices administering family assistance benefits to insure prompt registration at the time of application for payments.

It is the intention of the committee that employability plans be developed for registered recipients as promptly as possible. However, in order to assure orderly and effective administration of the manpower programs, the bill authorizes the Secretary of Labor to establish priorities for developing employability plans.

The committee recognizes that in the development of employability plans, there are factors over which the Secretary has no control, such as the condition of the labor market. In setting priorities for developing employability plans, the Secretary will need to take these factors into account, in addition to such considerations as family status and personal characteristics of the individual. Mothers who volunteer will be given the same consideration for participation as those who are referred on a mandatory basis.

Your committee specifically deleted a provision of the administration bill exempting the working poor from registering with the employment service. Requiring the working poor to register will provide assurance that every able-bodied individual in family assistance families will be registered for employment, except mothers with preschool children or persons who must care for a disabled individual in the home. In addition, registration will aid the employment service in assisting the working poor in upgrading their skills and income.

An individual required to register and who does not do so would not be counted as a member of the family for purposes of determining the amount of benefits, but any income that he has would be counted as a part of the family's income. An individual refusing to register would not be paid any part of the family assistance payment; the Secretary could, if he deemed it appropriate, pay the family's benefits to a person who is not a member of the family, but who is interested in, or concerned with, its welfare. These provisions closely follow those in present law.

Exclusions from the requirement to register would be made in the case of individuals who are so ill, incapacitated or of advanced age that they are unable to engage in gainful employment. The Secretary of Health, Education, and Welfare could by regulation prescribe when the age of a particular person, taking into account the person's health, education, and former training and any other pertinent conditions, was so advanced as to make registration unnecessary. In the case of any individual who is not required to register because of incapacity, provision is made for referral to the vocational rehabilitation agency so that rehabilitation for employment can be initiated. All existing rehabilitation services available should be applied in order to enhance the individual's capacity for self-support. The primary objective of rehabilitation services should be economic self-sufficiency through gainful employment. The vocational rehabilitation agency will make initial determinations of incapacity which precludes the individual from gainful employment, in a manner similar to that followed under present law by the Social Security Administration where the vocational rehabilitation agency makes initial disability determinations under the social security law. Subsequent review of the individual's incapacity and continuing need for vocational rehabilitation services would be made as necessary by the State agency, or, in the case of an individual who is not totally and permanently disabled, at least once each quarter.

Your committee believes that the effectiveness of the training and employment programs in the bill will be materially enhanced by the provisions requiring that persons not referred to the Department of Labor because of incapacity be referred to the vocational rehabilitation program. This program has demonstrated that large numbers of persons with vocational handicaps can, with medical care, counseling, and training around their handicaps, be made wholly or largely economically independent. The requirements for referral are the same as for persons being sent directly to manpower agencies. Undoubtedly some of the individuals initially sent to manpower agencies will be found to need vocational rehabilitation services before other training and placement can be effective. Such referrals can and should be made under the authority in the bill. Penalties equal to those for failure to participate in other manpower programs are appropriate and the bill so provides.

Your committee's bill would also exclude from mandatory registration children who are under age 16 or under age 21 and regular students. The administration's bill would only have required the registration of individuals over age 18. However, your committee believes that the training aspects of the family assistance program could be of great use in preparing youths age 16 and 17 not attending school for employment.

A mother of a child under the age of 6 who is actually caring for the child is not required to register. As a practical matter, the committee expects a large percentage of these mothers to voluntarily register for employment and take advantage of child-care provisions and training incentives and opportunities. That has been the experience under the present WIN program.

An additional exclusion is provided for the mother or other female caretaker of a child if there is an adult male related to the child in the home who is required to register and does so register. These mothers will also be entitled to voluntarily register for training and employment. If the father in this situation refuses to register, the mother would have to register.

A person whose presence in the home is required on a substantially continuous basis in order to care for an ill or incapacitated member of the household would not be required to register. This type of illness or incapacity would likely be more severe than the types discussed above, since a regular caretaker would have to be found necessary.

The Secretary is required to furnish child care services for so long as he determines appropriate when the individuals, after having been required to register, are participating in manpower services, training, or employment. No mother would be required to undertake training or employment without the assurance of adequate and necessary child care.

g. Denial of benefits in case of refusal of manpower services, training, or employment

Since the intent of your committee's bill is to insure that individuals have every opportunity to increase their capacity for self-support, provision has been made in the bill to insure that individuals who register actually participate in suitable manpower services, training, or employment. Your committee is proposing that a member of a family who, after registration and without good cause, refuses to participate or continue to participate in suitable manpower services, training, or employment would, after notice and opportunity for hearing, not be considered a family member for purposes of determining the family's benefit amount, except that his income would be counted. Good cause is determined by examining how a reasonable individual would act in the same circumstances. Thus, for example, employment or training opportunities could be refused if the individual were ill, or had an allergic reaction to materials with which he would be working in the course of employment or training. A woman might refuse such opportunities if the position offered were in a dangerous locality and at late hours. Similarly, a mother could refuse training or employment if adequate child care were not available.

In establishing standards of "suitability", your committee has relied heavily on the definition long in use under the State unemployment insurance laws, with modifications appropriate to the client group to be served.

The bill provides that in no event may employment be considered suitable if the position offered is vacant due directly to a strike, lock-out, or other labor dispute (including an organizational dispute); if the wages, hours, or other terms or conditions of employment are contrary to or less than those prescribed by Federal, State, or local law or are substantially less favorable to the individual than those

prevailing for similar work in the locality; or if, as a condition of being employed, the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization. It is your committee's intent that registrants should not be referred to positions where any of these conditions exist. These protections for the individual are based on similar provisions in the Federal Unemployment Tax Act. The suitable work provision operates both to protect the individual from unreasonable work requirements, and to assure that employment is required.

In those cases where exclusion from the family of such an individual would make a child ineligible for payments as in a two-member family, your committee's bill requires that such an individual should be considered a member of the family for eligibility but not for payment purposes. Furthermore, the bill requires that benefits for the other family members not be paid to the individual who refuses manpower services, training, or employment, but rather to another family member or to a person outside the family who is interested in, or concerned with, the welfare of the family.

The provisions governing hearings by the Secretary of Health, Education, and Welfare are made applicable to hearings by the Secretary of Labor in cases of refusal of manpower services, training, or employment. While it is a Federal responsibility to provide these hearings, your committee contemplates that the Secretary of Labor will utilize the expertise of the State employment security agencies in meeting this responsibility. Your committee expects the Secretary of Labor to contract with these agencies to furnish the required hearings, but your committee wishes to make clear that the Secretary of Labor will bear the responsibility to insure that hearings are held within the required 90 days.

h. Transfer of funds for on-the-job training programs

Under your committee's bill, the estimated amount of family assistance benefits that would otherwise be paid to individuals participating in public or private employer-compensated on-the-job training programs of the Secretary of Labor if they were not participating would be made available to the Secretary of Labor to help pay the costs of such programs. The Secretary of Health, Education, and Welfare and the Secretary of Labor shall provide by agreement the method of estimating the family assistance benefits and making the transfer of funds.

2. STATE SUPPLEMENTATION OF FAMILY ASSISTANCE BENEFITS

Your committee recognizes that the new family assistance benefits, would generally not provide a level of support for families equal to that now provided in many States for AFDC recipients. The bill requires, therefore, that the benefits would be augmented by supplementary payments under State plans. The bill provides that each State that was making AFDC payments higher than the new family assistance benefit, would be required to maintain the levels of payments in effect as of January 1, 1970, or, if lower, a level corresponding to the poverty level as defined in the bill. The bill provides also for partial Federal financing of State supplementary payments in order to support the efforts of the States in making such payments. There would not be any Federal financing of any State supplementary payments to the

working poor, nor is there any requirement that the States supplement payments to the working poor.

Your committee's bill would establish a formula for reimbursement of administrative expenses which would provide incentives for the States to contract with the Secretary of Health, Education, and Welfare for Federal administration of both the family assistance plan and the State supplementary programs. Your committee feels strongly that needy people should not be shuttled from window to window or agency to agency and that a single point of contact for recipients is highly desirable if the committee's proposals are to be effective.

a. Payments to States for other welfare programs conditioned on supplementation

Your committee's bill would require that in order for a State to be eligible to continue to receive Federal payments under part A of title IV (services to needy families with children) and part B (child-welfare services), title V (maternal, child health, and crippled children's services), title XVI (aid to the aged, blind, and disabled), and title XIX (medical assistance), the State would have to agree to supplement the family assistance benefits so that present payment levels (or, if lower, the poverty level) would be maintained. This supplement would be required for all families eligible for family assistance benefits except those where both parents are present, neither is incapacitated; and the father is not unemployed. Generally, this would mean that the States would supplement family assistance benefits for all recipients who could have been eligible under present law and—whether or not the State previously covered them—families with an unemployed parent. Since families headed by a father working full time are not assisted under present law, the States would not be required to supplement the family assistance benefits of these families.

b. Eligibility for and amount of the supplementary payments

Your committee's bill would provide that eligibility for, and the amount of, the supplementary payments would be determined generally under the rules and regulations that apply to the family assistance plan. Your committee believes that not only is this an important step toward the establishment of needed nationwide uniform standards for assistance, but a necessary one to facilitate Federal administration of the program.

As stated previously the bill would require that the amount of State supplementation be sufficient to assure payment levels at least as high as those in effect in the State in January 1970, or the poverty level, if lower. Thus in determining the State supplementary payment amounts, the State standards of need and payment limitations in effect for January 1970 would be applied (or if lower, the poverty level) unless the State wishes to apply a higher standard of need. If a State plan in effect on January 1, 1970 provided for meeting less than 100 percent of its needs standards or for considering less than 100 percent of its requirement in determining need, the Secretary would, by regulations, prescribe standards for insuring that the January 1970 payment levels would be maintained.

The amount of the supplementary benefit of a family would be reduced as under the family assistance plan, except that with respect to earned income the State would be required to disregard (1) \$720 of earned income per year plus (2) one-third of the earnings between

\$720 and twice the amount of the unreduced family assistant benefit ($2 \times \$1,600$ or \$3,200 for a family of four), plus (3) one-fifth (or more, if the Secretary so prescribes by regulation) of any remaining income.

For example, assume that a family of four has earned income of \$3,500 in a State which has a need standard of \$3,000.

A step-by-step computation of the State supplementary payment

State standard in January 1970.....	\$3,000
Treatment of family income:	
Family earnings.....	3,500
State to disregard—	
Amount set by law.....	—720
Remainder.....	2,780
Less $\frac{1}{3}$ of remainder (up to \$3,200).....	—927
Earnings chargeable.....	1,853
Family assistance benefit.....	1,600
Less $\frac{1}{2}$ of \$2,780 (\$3,500 of earnings less \$720).....	—1,390
Family assistance benefit.....	210
Total income chargeable.....	—2,063
State supplementary payment.....	937
Total income of family:	
Earnings.....	3,500
Family assistance payment.....	210
State supplementary payment.....	937
Total.....	4,647

Your committee's bill would require that agreements with the State for making supplementary payments would generally follow the lines of those in existence under the present AFDC programs. Generally, the plan must—

- (1) Be in effect statewide;
- (2) Designate a single State agency to carry out or supervise the agreement in the State;
- (3) Provide opportunity for a fair hearing;
- (4) Provide proper and efficient methods of administration, as well as for effective use of a paid subprofessional staff;
- (5) Agree to make reports as required by the Secretary;
- (6) Provide safeguards that restrict the disclosure of information; and
- (7) Provide that all individuals who wish to apply for payments shall have an opportunity to do so.

c. Payments to States

In order to assist the States in making supplementary payments the bill provides that the Federal Government generally would pay a State 30 percent of the amount expended by the State in making such payments each fiscal year, not including any supplementary payments made to the working poor. However, there would be no Federal payment for that part of the supplementary payment which exceeds the difference between the applicable poverty level and the sum of the family assistance payment and any income of the family not disregarded in computing the supplementary payments. An example of how

the Federal payment to a State would be figured for a family of four is as follows:

State standard	\$3, 000
Family income:	
Family earnings	1, 000
State to disregard—	
Amount set by law	—720
Remainder	280
Less $\frac{1}{2}$ of remainder (up to \$3,200)	—93
Earnings chargeable	187
Family assistance benefit	1, 600
Less: $\frac{1}{2}$ of \$280 (\$1,000 of earnings, —\$720)	—140
Family assistance chargeable	—1, 460
Total income chargeable	—1, 647
State supplement	1, 353
Poverty level	3, 720
Less total income chargeable	1, 647
Difference	2, 073

Since the State supplementary payment (\$1,353) does not exceed the difference (\$2,073) between the poverty level (\$3,720) and the family assistance benefit plus the earnings not disregarded (\$1,647), the Secretary would pay to the State \$405.90 (30 percent of the State supplementary payment of \$1,353). This complete computation would not actually be necessary in the case of any State which has a standard below the poverty level. Your committee has been informed that only one State has a standard above the poverty level at the present time.

The bill makes provision for annual redetermination of the poverty level by the Secretary. The Secretary would, between July 1 and September 30 of each year, promulgate the poverty level for various sizes and types of family groups to be effective for the purpose of setting the ceiling on Federal participation during the fiscal year beginning on the July 1 following the year of promulgation.

For purposes of the promulgation, this base for determining the level will be the 1969 poverty level for a family group as set fourth below:

Family size poverty level:	
1	\$1, 920
2	2, 460
3	2, 940
4	3, 720
5	4, 440
6	4, 980
7 or more	6, 120

Between July 1 and September 30 of each year beginning with 1970, the Secretary of Health, Education, and Welfare shall review and increase, if necessary, the poverty level amounts for each size of family group by the percentage increase in the Consumer Price Index (published each month by the Bureau of Labor Statistics) for the second calendar quarter of each such year over the Consumer Price Index for 1969; such increases shall be effective with respect to Federal matching for the year beginning July 1 of the next succeeding year.

d. Failure by State to comply with agreement

Your committee's bill permits the Secretary of Health, Education, and Welfare, after reasonable notice and opportunity for hearing, to withhold all or such portion as he deems appropriate of the payments otherwise due a State under titles IV (parts A, B, and E), V, XVI, and XIX if the Secretary finds that the State has failed to comply with its agreement.

Your committee is concerned by information that has been brought to its attention indicating that some States have not met effective dates promptly for some requirements of the Social Security Amendments of 1967 and that a few States have not met all of them even at this late date. It expects the Department of Health, Education and Welfare to take whatever steps may be necessary to assure full and prompt compliance with the requirements of Federal law.

3. ADMINISTRATION

It is the intent of your committee that a new agency would be established in the Department of Health, Education, and Welfare to administer the family assistance plan. The new agency would be responsible for establishing and managing local family assistance plan offices and would carry out other necessary functions with the exception of those which it may find appropriate to contract with other agencies to carry out. The committee would expect that other agencies within the Department, as well as other governmental agencies outside the Department, would lend their support to the extent that doing so would be consistent with the performance of the duties required to carry out their own programs, to assist the new agency in carrying out the provisions of the plan. For example, while the administration of the family assistance plan would be completely separate and distinct from the social insurance programs, the committee would expect that the computer equipment and other capabilities of the Social Security Administration would be utilized in the administration of the family assistance plan to the extent it is economical and efficient to do so, taking into account the mission of the new agency. No part of the cost of rendering such service, however, would be chargeable to the Trust Funds administered by the Social Security Administration.

Because the full development of administrative policies, procedures, and methods to carry out the program will require considerable time, and since the time permitted between enactment and effective date is limited, the committee believes it would be desirable for the Department to request an advance appropriation to cover the costs of full-scale administrative planning for implementing the program.

a. Agreements with States

Your committee's bill, as previously indicated, calls for State supplementation of Federal family assistance payments. However, your committee felt some concern lest such a dual program arrangement lead to unnecessarily complicated and expensive dual administrative systems—a Federal system for part D benefits, and State systems for part E benefits. Therefore, in addition to requiring that State supplementary plans follow Federal uniform definitions of eligibility and treatment of income, your committee has included provisions to encourage unified administration of the family assistance

plan and the State supplementary plans and it is the hope of the committee that the States will take advantage of these provisions. Under these provisions, the Secretary of Health, Education, and Welfare can enter into an agreement with any State under which the Secretary can administer and make State supplementary benefit payments on behalf of the State. Conversely, the provisions permit agreements between the Secretary of Health, Education, and Welfare and a State under which the State would administer and disburse the family assistance benefits provided for under part D as well as the State supplementary benefits.

If the Secretary entered into an agreement with a State to have the Federal Government administer the State's supplementary program, the Federal Government would then pay all administrative costs for the family assistance program and all administrative costs for the State's supplementary program, so that the State would realize substantial savings in administrative costs through such an arrangement. If a State chose to administer its own supplementary program, the Secretary of Health, Education, and Welfare would pay one-half of the State's administrative costs for its supplementary program. If the State agreed to administer the family assistance benefits provided for under part D, the Federal Government would reimburse the State for all of its administrative costs for part D and one-half the administrative costs of the State's supplementary program.

b. Penalties for fraud

Your committee strongly believes that every person attempting by unlawful means to obtain payments not due him under the plan, or otherwise violating any of the penal provisions of the Social Security Act, would represent a threat to an effective program. The threat goes beyond the potential drain on the funds appropriated for the program; a more important consideration is the impact such violations might have on public confidence in the integrity of the program. Under the Federal-State assistance programs, a State is required to make provisions for dealing with fraud committed by recipients. Federal regulations require that a State define fraud in accordance with State law, include criteria for identifying and investigating suspected fraud, and provide for the referral of appropriate cases to law enforcement officials. However, the procedures used in the States vary widely as to fraud in welfare cases. The criminal statutes of some States contain separate provisions for cases of welfare fraud; in other States, welfare fraud is prosecuted under the laws governing theft or one of any number of other crimes.

Your committee believes that for the family assistance plan the penalties for fraud should be the same as those provided under the social security program since the considerations that lead to provision of such penalties under social security would be equally relevant to the family assistance plan. These fraud provisions would apply only with respect to the basic family assistance program and not to the State supplementary programs.

c. Report, evaluation, research and demonstrations, and training and technical assistance

Your committee is very concerned about the need to improve the effectiveness of our national income maintenance programs. Accord-

ingly, the bill would require a constant process of self-examination by the administrators of the family assistance program and regular reports to the Congress and the President. Evaluation by outside consultants is also authorized.

Authorization would be given to the Secretary of Health, Education, and Welfare to conduct research and demonstration projects. Since such experimentation may well involve approaches or other ideas which have no specific sanction in existing statutes or regulations, authority would also be provided for the Secretary to operate experiments (limited in scope) without regard to the eligibility and payment-amounts provisions of the plan. As in the case of evaluations, the Secretary would be authorized to use contractors to conduct such research and demonstration projects.

The bill would also authorize the Secretary to provide technical assistance to States and to provide for such training of State personnel as the Secretary deems appropriate to assist the States in improving administration of assistance to people in need. Your committee believes that the additional funds available to carry out these provisions for evaluation activities, research and demonstrations, and technical assistance and training should be limited to no more than \$20 million per fiscal year and the bill so provides.

d. Obligation of deserting parent

One of the major causes of instability among AFDC families is parental desertion. To discourage abandonment of families, your committee's bill provides that an individual who has deserted or abandoned his spouse, child, or children shall owe a monetary obligation to the United States by the deserting parent equal to the total amount of family assistance benefits, plus the Federal share of any State supplementary payments, paid to the spouse or child during the period of desertion or abandonment. The liability of a deserting parent would be reduced by the amount of any payment he made to his family during the period of desertion.

In those cases where a court has issued an order for the support and maintenance of the deserted spouse or children, the obligations of the deserting parent would be limited to the amount specified by the court order.

To the extent these amounts are not collected directly from the individual involved, the amount due the United States under these provisions could be collected from any amounts otherwise due the deserting parent by any officer or agency of the United States or under any Federal program.

The terms desertion or abandonment are much broader than their meaning under State law. Physical absence from the home and a specific intention to desert need not be demonstrated, since a liability is created to the extent that an individual's failure to use his income and resources to support his spouse, child, or children, require that family assistance payments (and supplementary payments where applicable) be made to support them.

The individual applicant for family assistance benefits must, of course, cooperate to the fullest extent possible in establishing eligibility. In this connection, an individual applicant will be expected to cooperate in every possible way in assisting the authorities to identify and locate a deserting parent.

Your committee feels very strongly about these provisions and expresses unequivocally its intent that all Federal and State enforcement machinery should cooperate to the fullest extent possible in implementing these provisions.

e. Treatment of family assistance benefits as income for food stamp purposes

The bill provides that family assistance benefits shall be taken into account in determining entitlement to, and the cost of, food stamps.

Your committee feels that there is some merit in providing assistance to the needy both in the form of cash and in the form of food stamps. Doing so helps to assure that the family will spend a certain portion of its entire benefit for food. Your committee also feels that there is merit in providing assistance entirely in cash. The latter approach provides the recipient with more flexibility and is obviously more attractive from the standpoint of administration since a cash program is simpler to administer.

Your committee spent considerable time and effort attempting to work out a modification of the family assistance plan that would substitute additional cash payments for food stamps, but was unable to devise a satisfactory amendment. One possible change in the bill, to which the committee gave a great deal of attention, was that of combining the family assistance plan and the food stamp plan into a single, integrated cash-benefit program. Your committee finds that a program which provides all of its benefits in cash is substantially more expensive than one in which a portion of benefits are provided in cash and a portion in in-kind benefits, such as food stamps because the weighted structure of the food stamp benefit is such that the rate of participation declines as family income increases. Relatively few families are willing to tie up substantial portions of their cash in food stamps merely to obtain a small amount of additional food purchasing power. These same families would, of course, elect to take the value of their food stamp benefit if it were provided in cash. Your committee also notes that the food stamp plan provides a benefit to families who would not be covered by the family assistance plan. It also recognizes that present recipients now receiving payments larger than those provided under the family assistance plan would lose the privilege of purchasing food stamps without receiving a compensating amount of cash.

Your committee notes that the Secretary of Health, Education, and Welfare and the Secretary of Agriculture have both stated that cash assistance should eventually be substituted for food stamps in a way that would leave the individual at least as well off in total benefits. Your committee urges that the executive branch continue to explore the possibility and potential implication of combining food assistance programs and cash assistance programs into a single integrated system which meets all the maintenance requirements of needy families. Your committee feels very strongly that a solution to this problem must be achieved and it is recommended that the Committee on Ways and Means and the Committee on Agriculture jointly work out legislation at the earliest opportunity that would provide for integration of the two programs under a unified administration.

4. MANPOWER SERVICES, TRAINING, EMPLOYMENT, AND CHILD CARE PROGRAMS

Since the AFDC program is being repealed, the work incentive program for AFDC recipients is replaced by a broadened, strengthened program of manpower training and child care for recipients of the new family assistance program.

a. Operation of training and employment program

Your committee over the years has believed that a mechanism has to be developed which would make it possible for welfare recipients to develop into citizens who play a significant role as workers in the economy of the Nation. It is toward this end that your committee's bill includes provisions to train, prepare for employment, and otherwise assist recipients of family assistance and State supplementary payments in securing and retaining regular employment and having the opportunity for advancement in employment. It was also to this end that your committee first reported out legislation in 1962 which initiated the community work and training programs. These programs—and the title V programs of the Economic Opportunity Act which followed—were welfare agency administered work and training programs which often emphasized work at the expense of meaningful training that would lead to the family leaving the public assistance rolls. When Congress authorized the work incentive (WIN) program in 1967, it was with the belief that the growing experience of the Department of Labor and the State employment offices in providing manpower training for the disadvantaged made it logical that they administer the program.

This decision has been justified in many respects. One illustration of this is the innovative development of the manpower "team" staffing arrangement which makes available an assortment of specialists to the enrollees (including "coaches" often of the same ethnic background) as opposed to the more traditional approaches used in earlier manpower programs.

Your committee has just completed a survey of WIN projects in some 29 jurisdictions, and has heard the testimony of numerous WIN administrators and experts in the field, including the organization—the Auerbach Corporation—which has the prime contract for evaluation of the program. The performance of the WIN program to date has been mixed. In many jurisdictions it has performed well—the welfare agencies and the employment services cooperating in such a manner that the program is running relatively smoothly and with considerable promise of fulfilling the objectives outlined by Congress. In other jurisdictions—including, unfortunately, some of our largest metropolitan areas—the program has gotten off to a slow start. Often these programs have been characterized by minimal welfare and employment service cooperation and, in a few instances, the hostility of one agency toward the other has been openly expressed.

Moreover, the problem of competing bureaucracies has not been restricted to the State level. Secretary of Labor Shultz stated in his testimony before the committee:

Unfortunately, our two Departments [Labor and Health, Education, and Welfare] have not always worked together as smoothly as they should. The study made by the Legis-

lative Reference Service of the enactment of WIN establishes this fact. There have been gaps in communication, and a history of competition for running the work training program.

The committee strongly supports Secretary Shultz's position that Health, Education, and Welfare and Labor should work with the maximum of coordination in the administration of family assistance. This is essential to the effective operation of the proposed program.

This situation just outlined, coupled with a slowly developing program of child care for WIN mothers, which will be discussed subsequently in this section, makes necessary, however, a number of legislative changes in the training program.

(1) *Uniform referral system.*—The system of welfare agency determination of "appropriateness" of recipients for participation in the program and the resulting wide disparity in referral policy between the States are eliminated by the bill. Specific definition of the persons who are expected to register with the employment service office will eliminate the situation where, according to Department of Health, Education, and Welfare statistics, over 96 percent of the welfare recipients assessed for WIN participation in West Virginia were referred, while less than 7 percent of those assessed were referred in New York. Under the system proposed by the committee bill, welfare administrators and workers will not be able to substitute their own ideas of who should be trained for work for the national policy laid down by Congress. As a result, administrators of the manpower programs should, in all areas, have an adequate supply of candidates for their manpower training slots.

(2) *Supportive services and training expenses.*—Lack of necessary health and other supportive services has been particularly damaging to the effective operation of the WIN program in a number of States. The lack of medical examinations, the lack of ability to remedy minor health problems, and the lack of counseling services which might solve serious family problems all lead to unnecessary and wasteful terminations of participation in training or employment. Some States have established units in their welfare agencies which have worked effectively in getting welfare recipients into the program and in working with the manpower team in keeping them in training and on the job when they do enter employment. Under an amendment added by the committee, the bill would require, under threat of loss of Federal matching, that welfare agencies provide those supportive services which the Secretary of Health, Education, and Welfare determines to be necessary to support the work and training aspects of the program. The bill emphasizes the importance of such services by providing 90-percent Federal matching as opposed to the 75-percent matching for other social services which are not connected with the training program. Under the bill a State must have an agreement with the Secretary of Health, Education, and Welfare under which it must provide health, vocational rehabilitation, counseling, social and other supporting services for persons who undertake or continue manpower training or employment.

Your committee wishes to emphasize its intention that employment service-type activities in the welfare agencies should not be financed through the existing regular social service provision, or through the supporting services provision which was added by your committee's bill.

Another related problem of existing law has been reimbursement for training expenses which must come from the welfare side of the program. This has often resulted in delayed payments, multiple checks, and general inconvenience to the trainee which have had an adverse effect on his attitude toward the program. Under your committee's bill, the employment service could reimburse the trainee for necessary expenses directly related to his participation in training, such as transportation, lunches, special clothes, and supplies needed for the training.

(3) *Comprehensive manpower services.*—The 1967 WIN legislation authorized a comprehensive array of manpower and employment services. Your committee's bill is equally comprehensive as to the services made available and gives sufficient authority to the Department of Labor and the State employment service offices so that they may develop individual employment plans to meet the needs of individuals who have serious vocational, social, and educational handicaps. The committee bill will also assure access to services and opportunities available under existing manpower programs such as MDTA, CEP, JOBS, and other training programs of nationwide applicability. Such services and opportunities would include counseling, testing, work experience, institutional and on-the-job training, upgrading, program orientation, job development, coaching, job placement, and followup services required to assist in securing and retaining employment and opportunities for advancement. It is not intended by your committee that these programs should provide assistance which would be supportive of firms or industries which have high rates of turnover of labor because of low wages, seasonality or other factors.

(a) *On-the-job training.*—Your committee has been disappointed in the implementation of a number of the components of the existing program. On-the-job training opportunities under the WIN program—which currently are running at about 500 slots—have not been commensurate with the importance that the Congress has placed on this type of training. Spokesmen of the Department of Labor before the committee indicated that they have the administrative authority to deal with some of those elements which have impeded the development of OJT, such as voluminous small-print contracts which frighten small employers away from the program. The committee expects the Labor Department and the State employment services to devote special attention to the goal of making OJT a meaningful part of the program.

To make certain that such training is adequately financed, your committee's bill includes a special provision to provide funds for OJT. As stated previously, the estimated amount of family assistance benefits that would otherwise be paid to individuals participating in public or private employer-compensated OJT programs of the Secretary of Labor if they were not participating, would be made available to the Secretary of Labor to pay the costs of such programs.

It is not the intention of the committee, however, that the above provision will replace the regular authorized appropriations for OJT under this program, but will add to the overall effort.

(b) *Special work projects.*—The committee is also distressed that the special work project provision in WIN has only been implemented in a meaningful way in one State, despite the fact that the law re-

quired their implementation in *all* States. The bill renews and emphasizes the special work projects and eliminates the complex financing arrangements which the Department of Labor declares has inhibited their growth. Your committee fully expects wide implementation of special work projects. Your committee also believes that these projects may be of critical importance to the training and placement of welfare recipients if employment rates fall below existing levels.

The bill provides authority for special work projects which meet real public needs and which are conducted through grants and contracts with public or nonprofit private agencies or organizations. The employment records of participants in these projects shall be reviewed at least every 6 months for the purpose of determining whether it would be feasible to place such individuals in regular employment or in other kinds of training. The projects themselves should be selected for as much training value as possible so that they will improve the employability of the participants. It is not the intention of the committee that such projects be used for permanently subsidized employment, and measures should be taken to move participants into regular jobs.

The bill retains certain safeguards in present law with respect to special work projects. No wage rates provided under any special work project would be lower than the applicable minimum wage for the particular work concerned. In addition, appropriate workmen's compensation protections, and standards for the health, safety, and other conditions applicable to the performance of work and training would be established and maintained. Conditions of work, training, education, and employment should be reasonable in light of such factors as the type of work, geographical region, and proficiency of the participant.

(c) *Relocation assistance.*—Authority for relocation assistance is provided under the bill in situations where an individual volunteers to move from an area where the prospects for employment are poor to one that has a shortage of workers. Such assistance would be provided only when there is assurance, by the employment service office in the area to which the individual would be moved, that an actual full-time, full-year job is available. Further, such jobs must lead to wages sufficient to remove the family being assisted in the relocation from the family assistance rolls. The committee believes that such assistance should not be provided in the case of seasonal employment.

b. Allowances for individuals undergoing training

In some instances training incentive allowances have been unfair to WIN participants in that a person enrolled in a manpower development and training (MDTA) class might be sitting beside an MDTA enrollee who was receiving a substantially higher allowance. Your committee's bill would continue the WIN allowance of \$30 per month for each individual who is a member of a family and is participating in manpower training, but if his allowance under the MDTA program would be more than \$30 higher than family assistance payments (plus the State supplement), the incentive allowance to the family assistance trainee would be the difference between the two allowances.

Under the Manpower Development and Training Act, the basic allowance is computed on the basis of the average weekly gross unemployment compensation payment (including allowances for de-

pendents) for a week of total unemployment in the State making such payments during the most recent four-calendar-quarter period for which such data are available. This amount may be increased by up to \$10, and in addition \$5 a week for each dependent over two up to a maximum of four additional dependents. There are special provisions to deal with the situation in which an individual's unemployment compensation benefits would exceed his training allowance.

Thus, in most cases the financial incentive to take training will be in excess of \$30. In the case of North Dakota, for example, family assistance plus the State supplement would equal \$188 a month for a family of four. However, since the Manpower Development and Training Act allowance in that State for the head of a family of four is \$255, the incentive payment would be \$67 per month—the difference between \$188 and \$255.

The bill would provide for smaller training allowances for recipients in Puerto Rico, the Virgin Islands, and Guam.

c. Utilization of other programs

Your committee's bill would provide that the Secretary of Labor, in providing manpower training and employment services, would be authorized to use other existing programs and all sectors of the economy to the maximum extent feasible so that the establishment of an integrated and comprehensive program would result. The Secretary of Labor would be authorized to reimburse other public or private agencies, where necessary, for services rendered to persons under this part.

d. Appropriation and non-Federal share

Your committee's bill would authorize appropriation of funds sufficient to carry out the manpower provisions of the bill, including payment of up to 90 percent of the cost of training and employment and related supportive services for people registered under the family assistance plan. If the non-Federal matching requirement of 10 percent (which could be made in cash or in kind) was not met in any State, a portion of its Federal share of medicaid and other welfare expenditures would be withheld until the deficit was made up. The Secretary of Labor would apportion appropriated funds equitably among the States. In developing criteria for apportionment, the Secretary of labor shall consider the number of registrations and other relevant factors.

In addition to the training slots currently contemplated under the existing WIN program, the Administration has stated that training would be expanded to a total of 225,000 slots, including 75,000 for upgrading the skills of the working poor, in the first full year of the operation of the family assistance plan.

e. Child care. Your committee has been disturbed because necessary child care has not been available in many cases when it has been needed to enable a parent to participate in training and employment under the existing work incentive program. Lack of child care has, in fact, been one of the major drawbacks in the functioning of the program, as was shown by the committee's survey of WIN projects and by the evaluation study of the Auerbach Corp.

Your committee believes that a major effort is needed to remove lack of child care as a deterrent to training and employment. It also

recognizes that the availability of necessary child care is crucial to the success of the family assistance plan. The child care provisions, therefore, are aimed at making available the appropriate kind of child care needed by families who are covered by the Family Assistance Act.

Your committee's bill requires the Secretary of Health, Education, and Welfare, both directly (by contract or grant to public or private agencies) and through a system of prime grantees, to provide child care for individuals participating in training or employment under the manpower program. The Secretary is authorized to make grants for up to 100 percent of the costs of child care projects (including transportation, and the alteration, remodeling and renovation of facilities) to public or nonprofit private agencies which, in a particular geographic area will assure that child care is provided to persons entitled to receive it under the Family Assistance Act. The organization or agency to serve as the prime grantee for a geographical area is to be designated by the appropriate elected or appointed official or officials in that area. The prime grantee will be required to demonstrate a capacity to work effectively with the manpower agency. Where appropriate, group or institutional care for children attending school would be provided through local school systems arrangements with local educational agencies. Child care programs provided under the act would be of various kinds, providing for the kind of care needed in the light of different circumstances and needs of the children to be served. The Secretary is also authorized to charge a fee for part or all of the cost of child care if a family has the ability to make a payment.

Your committee believes that the child care provisions of the Family Assistance Act will help to overcome some of the obstacles which have inhibited the development and provision of child care services in the past. By providing for Federal initiative and responsibility and full Federal funding, your committee is making it possible for the Department of Health, Education, and Welfare to move expeditiously and quickly, without being required to wait for State or local organizations and agencies to provide matching programs and funding.

The committee also expects that the Department will use its grant and contract authority to make certain that the organizations and agencies involved will provide for a greater diversity in the kinds of child care than that which is currently available. For example, school age children could, in many cases, be most appropriately cared for in the school when care is needed in out-of-school hours. Parents should have the option, too, of using babysitters of their choice, if they do not care to use, or do not have available, group child care facilities which are appropriate for their children. The committee does not expect that day care centers will be used in cases where other kinds of care are more appropriate.

By requiring that the prime grantees demonstrate a capacity to work effectively with the manpower agency, the committee believes that a greater degree of coordination of manpower and child care services can be achieved than has been the case in previous programs.

The committee bill will make it possible to use a wider variety of child care resources than has been possible in the past. The Secretary of Health, Education, and Welfare will be able to make grants and contracts according to his determination of how family assistance recip-

ients can be served most effectively. He will be able to utilize public agencies, as well as private, nonprofit and profitmaking agencies and organizations. Thus, both the public and private sectors will be used in the provision of child care. The same authority will be available to prime grantees in entering into agreements within their areas of responsibility.

Your committee believes that well-designed child care programs, in addition to benefiting parents by freeing them for work, can also be of great benefit to the child and can help to break the cycle of poverty. Child care for the preschool child should not be merely custodial care, but should provide for child development, through the provision of health, educational, and other necessary services.

However, your committee is also concerned that unreasonable Federal, State, and local standards and licensing requirements have interfered with the provision of essential child care services, and may prove a barrier to the development and provision of the services essential to the success of the family assistance plan. Therefore, the Secretary of Health, Education, and Welfare is requested to furnish the committee by February 1, 1971, a report and recommendations based on a thorough review, in cooperation with State and local officials, of existing Federal standards as well as State and local licensing requirements, in order to determine those requirements which are essential both to protecting the child and assuring an appropriate program for him.

Your committee's bill also authorizes funds for grants to, and contracts with, any public or private agency or organization for part or all of the costs for evaluation, research, training of personnel, technical assistance or research or demonstration projects to determine more effective methods of providing child care services.

The Department of Health, Education, and Welfare has told the committee that it intends to request budget authority of \$386 million for child care purposes for the first full year of operation of the child care program. It estimates that it will provide services for 300,000 school age children at an estimated cost of \$400 per child and for 150,000 preschool children at an estimated cost of \$1,600 per child. A total of \$26 million would be designated for alteration, remodeling and renovation of facilities and for staff training and research and demonstration projects.

In order to assure that child care resources will be developed as rapidly as possible, your committee has provided that the child care provisions will be effective as soon as the bill is enacted into law.

f. Advance funding

(1) In order to give adequate notice of available funding, under your committee's bill, appropriations for one year to pay the cost of the program during the next year would be authorized.

(2) In order to make the transition to advance funding, initial funding under your committee's bill would provide for the year of enactment of this bill and for the next following year.

g. Evaluation and research: Reports to Congress

(1) Your committee's bill would provide for continuing evaluation and research by the Secretaries of Labor and Health, Education, and Welfare of the manpower training and employment programs provided under this act, including their effectiveness in achieving stated goals

and their impact on other related programs. The Secretary of Labor may conduct research and demonstration projects to improve the effectiveness of the manpower training and employment programs. He may also conduct demonstrations of improved training techniques for upgrading the skills of the working poor. The Secretary of Labor may, for these purposes, contract for independent evaluations of and research regarding such programs or individual projects under such programs, and establish a data collection, processing, and retrieval system.

Sums not to exceed \$15 million would be authorized for such research and evaluation in any fiscal year.

(2) The bill would require an annual report to the Congress from the Secretary of Labor on the programs for manpower training and employment services. The committee believes that an information and accounting system should be maintained so that the amount of money expended and services rendered under this program may be clearly distinguishable from those under other manpower programs. The Secretary of Health, Education, and Welfare also is required to file an annual report on the programs for child care and supportive services.

5. CONFORMING AMENDMENTS RELATING TO ASSISTANCE FOR NEEDY FAMILIES WITH CHILDREN

Your committee's bill would eliminate the provisions of the present AFDC program that relate to cash payments for families with dependent children, but would not substantially alter those provisions of title IV which provide services for families, foster care for children and emergency assistance. The requirement of the present AFDC program that the State plan of aid and services to families with children must be in effect in all political subdivisions of the State would be modified, as it would apply only to services. The bill would authorize the Secretary to permit certain exceptions to the "State-wideness" requirement.

B. CHANGES IN THE PROGRAM FOR THE AGED, BLIND, AND DISABLED

1. AID TO THE AGED, BLIND, AND DISABLED

Your committee has a continuing deep concern for those of our citizens who are in financial need because of old age or because of blindness or other crippling disabilities. Your committee believes that it is important at this time to revise the programs aiding these people in order to improve the substance and operation of these programs.

2. GRANTS TO STATES FOR AID TO THE AGED, BLIND, AND DISABLED

Your committee's bill amends the existing title XVI of the Social Security Act and sets forth the revised title XVI in its entirety. The existing title I (Old-age Assistance), title X (Aid to the Blind), and title XIV (Aid to the Permanently Disabled) would be repealed. Under the bill the new title represents the only federally aided public assistance program for needy aged, blind, or disabled individuals. In addition, Federal definitions would be substituted for those of the

individual States. The more uniform requirements are necessary to facilitate Federal administration of the program. The changes in the individual sections of title XVI are set forth below.

a. Appropriations

The section of your committee's bill which authorizes appropriations for aid to the aged, blind, and disabled under State plans, is amended to remove any reference to medical assistance, including medical assistance for the aged. This is because existing provisions of law preclude, as of January 1, 1970, Federal financial participation in medical assistance provided under any of the public assistance titles except title XIX (Medicaid).

b. State plans for financial assistance and services to the aged, blind, and disabled

Your committee's bill retains most of the existing State plan requirements relating to the programs of aid to the aged, blind and disabled, and adds several new requirements. Among new requirements is a periodic evaluation of the State plan at least annually, and an obligation on the part of the States to observe priorities and performance standards set by the Secretary in the administration of the State plan and in providing services thereunder.

The present prohibition against any age requirement of more than 65 years and against any citizenship requirement excluding U.S. citizens have been retained. Also, the bill requires that payments cannot be denied by a State, because of lack of citizenship, to an alien who has been residing in the United States for 5 years.

Your committee's bill prohibits any residency requirements that would exclude any resident of the State.

c. Determination of need

Your committee's great concern with the inadequacy and unevenness of assistance payments now being made to people in need because of old age, blindness, or disability, is reflected in the bill's provisions governing determination of need. The bill requires the States to pay cash assistance in an amount which, when added to nonexcluded income from other sources, guarantees income of at least \$110 per month per recipient. The bill would also require that the standard of need not be lower than the standard applied on the date of enactment under the State plan approved under the existing title XVI or (in case the State had not had such a plan) the appropriate one of the standards of need applied under the plans approved under titles I, X, and XIV. (It is recognized that some individuals in nursing homes and institutions have a large part of their needs met under other programs and that any dollar minimum should not apply to them.)

The bill would require the States to use the same definition of allowable resources as provided for in the family assistance plan (see page 3).

Your committee's bill would also provide that the States could not impose any responsibility for a relative to support the individual; except that a State could require that a spouse support the recipient or that parents support a child who is under 21 or blind or severely disabled.

Under existing law, a State may (at its option) disregard the first \$20 of earnings of an aged person and one-half of the next \$60 per

month. Your committee's bill changes the optional disregard provision to make it the same as that in the family assistance program—the first \$60 per month plus one-half of the remainder.

Your committee also believes that the earnings exemption for the severely disabled should be liberalized and made mandatory on the States and the bill so provides. The bill makes it consistent with that which has been in effect for some years for the blind, i.e., a mandatory exemption of \$85 per month plus one-half of the remainder, together with any additional amounts that are disregarded under an approved plan of vocational rehabilitation. Your committee believes this change will provide more meaningful encouragement for severely disabled persons to accept rehabilitation services and employment within their capacities and will assure equitable treatment as between blind individuals and individuals with other forms of severe disability.

The bill would retain the present mandatory disregard of the exemption of the first \$85 of earnings per month in the case of the blind. Also, as under present law, \$7.50 in any income for the aged, blind, or disabled, could be disregarded at the option of the States.

d. Payments to States for aid to the aged, blind, and disabled

Your committee's bill would establish the following new Federal matching formula with respect to expenditures for aid to the aged, blind, and disabled under State plans approved under the new title XVI. With respect to such assistance, the Federal Government would make the following Federal contribution: (1) 90 percent of the first \$65 of average payment, plus (2) 25 percent of the balance up to a maximum set by the Secretary of Health, Education, and Welfare.

e. Alternative provision for direct Federal payments to individuals

The bill contains new authority which would permit the Secretary of Health, Education, and Welfare to enter into agreements with any State under which the Secretary would make the payments directly to the eligible individuals. Under such an agreement the Federal Government would pay all of the administrative costs. Your committee believes that this authority will make possible economies in operation that are generally associated with unified administration.

f. Overpayments and underpayments

Your committee's bill would require that the Secretary of Health, Education, and Welfare make appropriate provision to avoid penalizing recipients for past overpayments if they were without fault and if adjustment or recovery would defeat the purposes of the program or be against equity or good conscience or (because of the small amount involved) impede efficient or effective administration.

g. Operation of State plans

The bill sets out conditions under which the Secretary of Health, Education, and Welfare would withhold Federal funds in whole or in part when the Secretary, after reasonable notice and opportunity for hearing to the State agency, finds that the State plan for aid to the aged, blind, and disabled no longer complies with the plan requirements.

h. Payments to States for services and administration

The bill provides, that, with respect to services for which expenditures are made under the approved State plan, the Federal Gov-

ernment would pay the same percentages of costs as under existing law—that is, 75 percent in the case of the training of personnel and certain specified services and 50 percent in the case of the other costs of administering the State plan. The bill also retains the provision under which 75-percent matching is available only when the State plan provides for the minimum services for self-support or self-care prescribed by the Secretary of Health, Education, and Welfare.

i. Computation of payments to States

Your committee's bill authorizes the Secretary of Health, Education, and Welfare to estimate before each quarter the amount a State is entitled to for aid, services, and administration for that quarter, and authorizes the Secretary to pay the estimated amount in installments adjusted by any overpayment or underpayment for any prior quarter. This continues the arrangement under present law.

j. Definition

Under existing law eligibility on account of disability is limited to those who are permanently and totally disabled, while your committee's bill would provide aid to those who are "severely" disabled. The bill would also specify that whether an individual is blind or severely disabled would be determined in accordance with criteria prescribed by the Secretary, whereas under present law there are no federally prescribed criteria for determining whether an individual is blind or totally disabled.

The committee expects that severely disabled will be interpreted to mean persons whose physical or mental conditions substantially preclude them from engaging in gainful employment or self-employment. It is also expected that the disability is one that has or can be expected to last for a period of 12 months or result in death. Thus, the definition of severely disabled would follow closely the definition now used for disability insurance benefits under title II.

Your committee understands that all but a very few States use essentially the same definition of blindness insofar as central visual acuity is concerned (i.e., less than 20/200 in the better eye with maximum correction). It accordingly believes that a uniform national definition is warranted at this time.

k. Repeal of titles I, X, and XIV of the Social Security Act

Your committee's bill would repeal titles I, X, and XIV, which are replaced by the provisions of the present bill.

C. MISCELLANEOUS CONFORMING AMENDMENTS

Your committee's bill would make a number of necessary conforming changes in titles IV, XI, XVIII, XIX of the Social Security Act.

It would also amend the Social Security Amendments of 1969. Section 1007 of these amendments is a provision for passing along some of the social security benefit increase provided under those amendments to public assistance recipients. The provision requires each State to assure that every recipient in the adult categories of public assistance who receives a social security benefit will receive a \$4 monthly increase in total income (either by disregarding that part of the social security benefit or by raising the State's standard of assistance for all recipients). This provision was made applicable only through June 1970.

Under your committee's bill the requirement would be made permanent.

D. GENERAL

1. EFFECTIVE DATE

The changes made in the bill, other than the child care provisions would be effective with July 1, 1971, except for those States which have statutes which prevent them from making the supplementary payments required by the new part E of title IV and whose legislatures have not met and adjourned by July 1, 1971. The committee has been informed that only a few States would be in this situation. The bill would be effective on July 1, 1972, or earlier if the State certifies that the statutory impediment no longer exists. The child care provisions would be effective upon enactment of the bill.

2. SAVING PROVISION

Your committee's bill assures that for 2 fiscal years after the year in which the supplementary payment provisions become effective a State's expenditures for supplementary payments and payments under title XVI (from its own funds) would not by reason of the requirements of this act have to exceed its expenditures (non-Federal) under existing law for the same year. The bill provides that for these 2 fiscal years the Federal Government would meet the excess of non-Federal expenses made necessary by the bill over what the non-Federal expense would have been under present law. States and localities would thus be guaranteed no required increase in expenditures for assistance payments as compared with what would have been expended under existing law for the same period. Since most States would not be required to incur additional costs as a result of enactment of this bill, this provision would act as a saving provision for a few States that would incur relatively modest welfare costs under the bill.

3. SPECIAL PROVISIONS FOR PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

Your committee's bill includes special provisions for Puerto Rico, the Virgin Islands, and Guam under which the amount of family assistance benefits, and all of the amounts used under the family assistance plan (other than the \$720 amount of annual earnings to be disregarded) and the new title XVI of the Social Security Act (aid to the aged, blind, and disabled), would be adjusted (but only downward) as the per capita income of each is related to the per capita income of the lowest per capita income State.

IV. FINANCING THE FAMILY ASSISTANCE ACT

The cost in calendar year 1968 terms to the Federal Government of your committee's bill is \$4.4 billion above expenditures under present law, the same as the cost of the welfare recommendations submitted to the Congress by President Nixon in October 1969. This estimate is based upon information furnished to your committee by the Department of Health, Education, and Welfare. The 1968 figures are the latest available and the reason they are used is ex-

plained in the discussion below under the heading Federal Control of Costs. However, the components of cost differ, as shown in the table below:

NET COST COMPARISON: PRESIDENT'S PROPOSAL VS. COMMITTEE BILL, CALENDAR YEAR 1968¹

	President's proposal	Committee bill
	(billions)	(billions)
Payments to families ²	\$3.0	\$2.6
Payments to States under pt. E ³.....	.1	.4
Adult assistance.....	.4	.5
Training and day care ⁴.....	.6	.6
Administration and other.....	.3	.3
Total.....	4.4	4.4

¹ The Department of Health, Education, and Welfare was not able to furnish all of the cost information presented on the basis of the figures applying to the fiscal year 1972, the first full year under the proposed programs. The costs are expressed, therefore, in terms of what the programs would have cost had they been in operation in 1968 (but including the effects of the 15 percent general increase in social security benefits effective this year).

² This item is the estimated cost of the family assistance plan payments to low-income families with children minus the cost of the Federal share of AFDC payments under existing law.

³ For the President's proposal, this item is the cost of the "50-90" rule (explained below). For the committee bill, it is the cost of the 30-percent Federal matching of State supplemental payments plus the cost of the saving provision described on page —.

⁴ These figures are not in the bill; they are the figures the administration has indicated it will include in the 1972 budget for such purposes.

Several of the changes made by your committee affect the way in which the Federal Government will incur costs and the financial impact on individual States. Chief among the changes were (1) deletion of a provision which permitted one-half of unearned income to be disregarded in computing the family assistance benefits; (2) deletion of a provision which assured the States a savings of 10 percent of their costs in the federally-assisted public assistance programs and which also required certain States to spend at least 50 percent of these costs (the "50-90" rule); (3) the inclusion of a new provision under which the Federal Government will pay 30 percent of a State's supplementary payment costs (up to the poverty level); and (4) increasing the minimum income payment (to an individual with no other income) in the adult categories from \$90 per recipient to \$110 per month.

The deletion of the unearned income exemption resulted in lowered costs sufficient to finance your committee's changes. In addition, the recently enacted changes in social security benefits lowered costs of public assistance for both the Federal Government and the States. A summary of the cost impact of these changes is shown below.

	Billion
Reduction in cost due to deletion of unearned income exemption.....	—\$0.4
Reduction in cost due to deletion of "50-90" rule.....	— .1
Reduction in cost from social security benefit increases.....	— .1
Cost of 30-percent Federal matching of State supplementary payments.....	+ .4
Cost of increasing the minimum income standards in the adult categories..	+ .2
Total.....	0.0

The total fiscal savings afforded to the States by your committee's bill are about the same as those which the States would have achieved under the administration's proposal. The way in which the States share in this fiscal relief, however, is substantially changed. In general, States which have been making greater fiscal effort in their welfare programs achieve more savings than they would have under the

President's proposed legislation. This results from the combined impact of the change to the 30 percent matching in State supplementary payment costs, which helps States with higher benefit levels, and the increased minimum income standards, which require States which have relatively low benefit levels in their adult category programs to increase their fiscal effort. A comparison of fiscal relief under the administration's initial proposals and under your committee's bill is shown below.

TABLE 1.—COMPARISON OF STATE FISCAL RELIEF, ADMINISTRATION PROPOSAL VERSUS COMMITTEE BILL, FISCAL YEAR 1968

[In millions of dollars]

	Adminis- tration bill	Committee bill		Adminis- tration bill	Committee bill
Alabama.....	\$12.0	\$4.0	Nebraska.....	\$0.7	\$2.5
Alaska.....	.4	.8	Nevada.....	.6	.8
Arizona.....	3.4	2.6	New Hampshire.....	.4	.1
Arkansas.....	6.5	(¹)	New Jersey.....	7.8	17.0
California.....	107.0	173.0	New Mexico.....	3.2	2.8
Colorado.....	9.7	12.1	New York.....	43.9	62.4
Connecticut.....	2.6	8.0	North Carolina.....	10.4	(¹)
Delaware.....	.9	1.3	North Dakota.....	.3	(¹)
District of Columbia.....	2.8	2.4	Ohio.....	31.0	31.9
Florida.....	8.6	4.5	Oklahoma.....	16.3	9.0
Georgia.....	12.5	(¹)	Oregon.....	4.6	5.2
Hawaii.....	2.0	3.6	Pennsylvania.....	27.6	38.9
Idaho.....	.4	.3	Rhode Island.....	2.5	3.6
Illinois.....	22.4	39.7	South Carolina.....	2.5	(¹)
Indiana.....	2.8	4.9	South Dakota.....	.4	.1
Iowa.....	2.9	(¹)	Tennessee.....	8.6	2.3
Kansas.....	2.6	5.7	Texas.....	25.1	4.8
Kentucky.....	10.6	(¹)	Utah.....	2.3	1.3
Louisiana.....	17.2	4.4	Vermont.....	.4	.1
Maine.....	1.3	2.6	Virginia.....	4.7	5.6
Maryland.....	12.6	10.8	Washington.....	7.2	13.7
Massachusetts.....	12.9	41.2	West Virginia.....	4.5	2.0
Michigan.....	14.4	27.1	Wisconsin.....	6.2	8.5
Minnesota.....	2.9	4.6	Wyoming.....	.2	.3
Mississippi.....	4.7	(¹)			
Missouri.....	12.1	(¹)			
Montana.....	.7	1.1	Total.....	500.3	567.6

¹ These States would not obtain any fiscal relief but would be protected from incurring additional costs by the saving provision in H.R. 16311 for 2 fiscal years after enactment.

TABLE II.—1968 FEDERAL AND NON-FEDERAL COSTS OF PUBLIC ASSISTANCE BY STATE AND PROGRAM (EXISTING LAW)¹

[In millions]

	Combined programs			Adult programs			Family programs		
	Total	Federal	Non-Federal	Total	Federal	Non-Federal	Total	Federal	Non-Federal
Alabama.....	\$113.3	\$87.8	\$25.5	\$96.4	\$73.7	\$22.7	\$16.9	\$14.1	\$2.8
Alaska.....	5.2	2.8	2.4	2.5	1.3	1.2	2.7	1.5	1.2
Arizona.....	28.0	21.4	6.6	13.2	9.9	3.3	14.8	11.5	3.3
Arkansas.....	57.8	45.1	12.7	48.8	37.9	10.9	9.0	7.2	1.8
California.....	1,018.6	533.5	548.1	620.4	310.2	310.2	461.2	223.2	237.9
Colorado.....	67.8	40.3	27.4	42.7	27.5	15.2	25.1	12.8	12.3
Connecticut.....	66.8	30.4	36.4	16.4	8.2	8.2	50.4	22.2	28.2
Delaware.....	9.8	6.4	3.4	3.0	1.8	1.2	6.8	4.6	2.2
District of Columbia.....	20.2	11.6	8.6	7.4	4.4	3.0	12.8	7.2	5.6
Florida.....	92.4	72.5	19.9	57.2	44.2	13.0	35.2	28.3	6.9
Georgia.....	115.1	89.8	25.3	79.7	62.1	17.6	35.4	27.7	7.7
Hawaii.....	15.8	7.8	8.0	4.6	2.3	2.3	11.2	5.5	5.7
Idaho.....	12.0	8.1	3.9	5.2	3.5	1.7	6.8	4.6	2.2
Illinois.....	228.3	124.0	104.3	70.2	45.1	25.1	158.1	78.9	79.2
Indiana.....	33.7	21.3	12.4	13.1	9.9	3.2	20.6	11.4	9.2
Iowa.....	65.8	39.2	26.6	35.7	21.3	14.4	30.1	17.9	12.2
Kansas.....	42.6	24.4	18.2	20.0	11.6	8.4	22.6	12.8	9.8
Kentucky.....	93.4	71.9	21.5	55.4	42.8	12.6	38.0	29.1	8.9
Louisiana.....	157.0	119.6	37.4	116.1	87.5	28.6	40.9	32.1	8.8
Maine.....	18.8	13.6	5.2	10.6	8.0	2.6	8.2	5.6	2.6
Maryland.....	74.8	44.4	30.4	22.3	14.1	8.2	52.5	30.3	22.2
Massachusetts.....	182.6	77.6	105.0	75.3	37.6	37.7	107.3	40.0	67.3
Michigan.....	163.8	87.1	76.7	58.5	35.8	22.7	105.3	51.3	54.0
Minnesota.....	68.0	39.7	28.3	27.6	16.1	11.5	40.4	23.6	16.8
Mississippi.....	58.7	48.0	10.7	48.1	39.2	8.9	10.6	8.8	1.8
Missouri.....	134.2	94.3	39.9	97.8	67.2	30.6	36.4	27.1	9.3
Montana.....	8.9	6.0	2.9	4.5	3.2	1.3	4.4	2.8	1.6
Nebraska.....	19.8	13.1	6.7	8.8	6.4	2.49	11.0	6.7	4.3
Nevada.....	5.6	3.8	1.8	2.6	1.7	.9	3.0	2.1	.9
New Hampshire.....	10.3	6.2	4.1	7.1	4.3	2.8	3.2	1.9	1.3
New Jersey.....	136.2	56.5	79.7	29.0	15.9	13.1	107.2	40.6	66.6
New Mexico.....	27.6	21.1	6.5	12.4	9.5	2.9	15.2	11.6	3.6
New York.....	894.0	441.9	452.1	176.2	88.1	88.1	717.8	353.8	364.0
North Carolina.....	93.1	69.9	23.2	59.1	44.1	15.0	34.0	25.8	8.2
North Dakota.....	11.6	8.2	3.4	6.0	4.3	1.7	5.6	3.9	1.7
Ohio.....	168.6	108.6	60.0	69.3	48.2	21.1	99.3	60.4	38.9
Oklahoma.....	125.0	90.8	34.2	87.7	64.7	23.0	37.3	26.1	11.2
Oregon.....	31.0	18.1	12.9	10.9	6.9	4.0	20.1	11.2	8.9
Pennsylvania.....	229.3	129.3	100.0	83.9	46.2	37.7	145.4	83.1	62.3
Rhode Island.....	22.1	12.2	9.9	5.6	4.0	1.6	16.5	8.2	8.3
South Carolina.....	24.3	19.5	4.8	17.4	13.8	3.6	6.9	5.7	1.2
South Dakota.....	11.9	8.6	3.3	4.6	3.4	1.2	7.3	5.2	2.1
Tennessee.....	78.9	61.3	17.6	47.1	36.6	10.5	31.8	24.7	7.1
Texas.....	211.3	162.8	48.5	177.4	135.2	42.2	33.9	27.6	6.3
Utah.....	18.3	12.7	5.6	6.1	4.7	1.4	12.2	8.0	4.2
Vermont.....	11.0	7.5	3.5	5.6	3.9	1.7	5.4	3.6	1.8
Virginia.....	38.4	28.3	10.1	15.7	11.6	4.1	22.7	16.7	6.0
Washington.....	70.5	38.8	31.7	30.0	19.8	10.2	40.5	19.0	21.5
West Virginia.....	41.4	31.9	9.5	13.6	10.3	3.3	27.8	21.6	6.2
Wisconsin.....	64.9	33.2	31.7	27.2	15.4	11.8	37.7	17.8	19.9
Wyoming.....	4.7	3.0	1.7	2.7	1.8	.9	2.0	1.2	.8
Total.....	5,366.2	3,155.9	2,210.3	2,558.7	1,627.2	931.5	2,807.5	1,528.7	1,278.8

¹ Family program costs are actual for calendar year 1968 whereas adult program costs are based on 1 month, and annualized to reflect full-year costs. Figures for adult programs are slightly higher than actual calendar year 1966 experience. Data are for federally assisted programs only; i.e., general assistance programs are not included.

TABLE III.—NET CHANGE IN 1968 FEDERAL AND NON-FEDERAL COSTS OF PUBLIC ASSISTANCE RESULTING FROM COMMITTEE BILL¹ BY STATE AND PROGRAM

[In millions]

	Combined programs			Adult programs			Family programs		
	Total	Federal	Non-Federal	Total	Federal	Non-Federal	Total	Federal	Non-Federal
Alabama.....	\$40.4	\$44.4	—\$4.0	\$19.5	\$20.7	—\$1.2	\$20.9	\$23.7	—\$2.8
Alaska.....	.8	1.6	— .8	.....	.4	— .4	.8	1.2	— .4
Arizona.....	7.9	10.5	—2.6	4.4	3.8	.6	3.5	6.7	—3.2
Arkansas.....	35.5	35.5	.....	28.1	18.5	9.6	7.4	9.2	—1.8
California.....	25.1	198.1	—173.0	—5.3	64.6	—69.9	30.4	133.5	—103.1
Colorado.....	3.9	16.0	—12.1	1.1	6.0	—4.9	2.8	10.0	—7.2
Connecticut.....	5.1	13.1	—8.0	.3	2.7	—2.4	4.8	10.4	—5.6
Delaware.....	1.2	2.5	—1.3	.4	.7	— .3	.8	1.8	—1.0
District of Columbia.....	4.0	6.4	—2.4	2.5	1.8	.7	1.5	4.6	—3.1
Florida.....	49.0	53.5	—4.5	20.4	19.8	.6	28.6	33.7	—5.1
Georgia.....	60.5	60.5	.....	45.9	31.8	14.1	14.6	19.8	—5.2
Hawaii.....	.1	3.7	—3.6	.1	.7	— .6	.....	3.0	—3.0
Idaho.....	2.3	2.6	— .3	.3	.9	— .6	2.0	1.7	.3
Illinois.....	20.3	60.0	—39.7	4.8	11.5	—6.7	15.5	48.5	—33.0
Indiana.....	14.4	19.3	—4.9	4.9	5.4	— .5	9.5	13.9	—4.4
Iowa.....	11.3	11.3	.....	2.7	1.7	1.0	8.6	7.8	.8
Kansas.....	2.4	8.1	—5.7	1.2	3.5	—2.3	1.2	4.6	—3.4
Kentucky.....	34.7	34.7	.....	25.4	18.0	7.4	9.3	15.0	—5.7
Louisiana.....	36.3	40.6	—4.4	22.9	18.5	4.4	13.3	22.1	—8.8
Maine.....	1.8	4.4	—2.6	— .4	.9	—1.3	2.2	3.5	—1.3
Maryland.....	9.5	20.3	—10.8	8.3	5.6	2.7	1.2	14.7	—13.5
Massachusetts.....	1.1	42.3	—41.2	— .7	13.4	—14.1	1.8	28.9	—27.1
Michigan.....	13.8	40.9	—27.1	1.5	8.9	—7.4	12.3	32.0	—19.7
Minnesota.....	11.6	16.2	—4.6	1.4	6.9	—5.5	10.2	9.3	.9
Mississippi.....	85.0	85.0	.....	54.7	34.8	19.9	30.3	32.1	—1.8
Missouri.....	37.1	37.1	.....	24.2	17.2	7.0	12.9	18.2	—5.3
Montana.....	1.7	2.8	—1.1	.2	.7	— .5	1.5	2.1	— .6
Nebraska.....	1.6	4.1	—2.5	.2	1.4	—1.2	1.4	2.7	—1.3
Nevada.....	1.0	1.8	— .8	— .2	.2	— .4	1.2	1.6	— .4
New Hampshire.....	1.3	1.4	— .1	— .1	.....	.....	1.4	1.5	— .1
New Jersey.....	29.5	46.5	—17.0	.2	4.2	—4.0	29.3	42.3	—13.0
New Mexico.....	5.5	8.3	—2.8	1.8	2.5	— .7	3.7	5.8	—2.1
New York.....	70.5	132.9	—62.4	2.5	27.3	—24.8	68.0	105.6	—37.6
North Carolina.....	33.1	33.1	.....	18.8	9.8	9.0	14.3	20.7	—6.4
North Dakota.....	2.1	2.1	.....	.3	.2	.1	1.8	1.3	.5
Ohio.....	14.5	46.4	—31.9	3.1	13.4	—10.3	11.4	33.0	—21.6
Oklahoma.....	5.4	14.4	—9.0	5.1	5.8	— .7	.3	8.6	—8.3
Oregon.....	2.8	8.0	—5.2	1.9	2.4	— .5	.9	5.6	—4.7
Pennsylvania.....	18.8	57.7	—38.9	9.9	17.4	—7.5	8.9	40.3	—31.4
Rhode Island.....	3.3	6.9	—3.6	.1	1.2	—1.1	3.2	5.7	—2.5
South Carolina.....	20.7	20.7	.....	12.8	9.5	3.3	7.9	9.1	—1.2
South Dakota.....	2.3	2.4	— .1	.3	.8	— .5	2.0	1.6	.4
Tennessee.....	31.4	33.7	—2.3	21.6	16.9	4.7	9.8	16.8	—7.0
Texas.....	72.6	77.4	—4.8	43.9	42.8	1.1	28.7	34.6	—5.9
Utah.....	4.1	5.4	—1.3	3.3	2.4	.9	.8	3.0	—2.2
Vermont.....	1.2	1.3	— .1	.....	.4	— .4	1.2	.9	.3
Virginia.....	7.5	13.1	—5.6	1.2	2.2	—1.0	6.3	10.9	—4.6
Washington.....	.8	14.5	—13.7	.....	4.8	—4.8	.8	9.7	—8.9
West Virginia.....	13.7	15.7	—2.0	6.1	3.7	2.4	7.6	12.0	—4.4
Wisconsin.....	8.8	17.3	—8.5	.9	3.9	—3.0	7.9	13.4	—5.5
Wyoming.....	1.1	1.4	— .3	.2	.3	— .1	.9	1.1	— .2
Total.....	870.3	1,436.1	567.6	402.7	492.8	—90.1	467.6	899.8	—432.2

*These States have extensive General Assistance programs for the working poor. They will derive additional fiscal relief from the Family Assistance Plan beyond what is shown here.

¹ The impact of the saving proviso¹ is shown in the combined program columns. States that would otherwise incur costs from the Committee bill are shown as obtaining no fiscal relief. Federal costs are increased by the amount estimated as reimbursable to the State.

TABLE IV.—1968 FEDERAL AND NON-FEDERAL COSTS OF PUBLIC ASSISTANCE BY STATE AND PROGRAM
(COMMITTEE BILL)¹

[In millions]

	Combined programs ²			Adult programs			Family programs			Payments to "working poor" ³
	Total	Federal	Non-Federal	Total	Federal	Non-Federal	Total	Federal	Non-Federal	
Alabama.....	\$153.7	\$132.2	\$21.5	\$115.9	\$94.4	\$21.5	\$37.8	\$37.8	-----	\$75.6
Alaska.....	6.0	4.4	1.6	2.5	1.7	.8	3.5	2.7	\$0.8	2.1
Arizona.....	35.9	31.9	4.0	17.6	13.7	3.9	18.3	18.2	.1	1.7
Arkansas.....	93.3	72.8	20.5	76.9	56.4	20.5	16.4	16.4	-----	16.8
California.....	1,106.7	731.6	375.1	615.1	374.8	240.3	491.6	356.8	134.8	117.6
Colorado.....	71.7	56.3	15.4	43.8	33.5	10.3	27.9	22.8	5.1	16.8
Connecticut.....	71.9	43.5	28.4	16.7	10.9	5.8	55.2	32.6	22.6	12.6
Delaware.....	11.0	8.9	2.1	3.4	2.5	.9	6.6	7.4	1.2	4.2
District of Columbia.....	24.2	18.0	6.2	9.9	6.2	3.7	14.3	11.8	2.5	8.4
Florida.....	141.4	126.0	15.4	77.6	64.0	13.6	63.8	62.0	1.8	73.5
Georgia.....	175.6	141.4	34.2	125.6	93.9	31.7	50.0	47.5	2.5	81.9
Hawaii.....	15.9	11.5	4.4	4.7	3.0	1.7	11.2	8.5	2.7	-----
Idaho.....	14.3	10.7	3.6	5.5	4.4	-----	1.1	8.8	6.3	6.3
Illinois.....	248.6	184.0	64.6	75.0	56.6	18.4	173.6	127.4	46.2	6.3
Indiana.....	48.1	40.6	7.5	18.0	15.3	2.7	30.1	25.3	4.8	77.7
Iowa.....	77.1	48.7	28.4	38.4	23.0	15.4	38.7	25.7	13.0	42.0
Kansas.....	45.0	32.5	12.5	21.2	15.1	6.1	23.8	17.4	6.4	31.5
Kentucky.....	128.1	104.9	23.2	80.8	60.8	20.0	47.3	44.1	3.2	23.1
Louisiana.....	193.2	160.2	33.0	139.0	106.0	33.0	54.2	54.2	-----	60.9
Maine.....	20.6	18.0	2.6	10.2	8.9	1.3	10.4	9.1	1.3	69.3
Maryland.....	84.3	64.7	19.6	30.6	19.7	10.9	53.7	45.0	8.7	12.6
Massachusetts.....	183.7	119.9	63.8	74.6	51.0	23.6	109.1	68.9	40.2	29.4
Michigan.....	177.6	128.0	49.6	60.0	44.7	15.3	117.6	83.3	34.3	33.6
Minnesota.....	79.6	55.9	23.7	29.0	23.0	6.0	50.6	32.9	17.7	67.2
Mississippi.....	143.7	114.9	28.8	102.8	74.0	28.8	40.9	40.9	-----	35.7
Missouri.....	171.3	129.7	41.6	122.0	84.4	37.6	49.3	45.3	4.0	63.0
Montana.....	10.6	8.8	1.8	4.7	3.9	.8	5.9	4.9	1.0	56.7
Nebraska.....	21.4	17.2	4.2	9.0	7.8	1.2	12.4	9.4	3.0	8.4
Nevada.....	6.6	5.6	1.0	2.4	1.9	.5	4.2	3.7	.5	16.8
New Hampshire.....	11.6	7.6	4.0	7.0	4.2	2.8	4.6	3.4	1.2	2.1
New Jersey.....	165.7	103.0	62.7	29.2	20.1	9.1	136.5	82.9	53.6	35.7
New Mexico.....	33.1	29.4	3.7	14.2	12.0	2.2	18.9	17.4	1.5	14.7
New York.....	964.5	574.8	389.7	178.7	115.4	63.3	785.8	459.4	326.4	126.0
North Carolina.....	126.2	100.4	25.8	77.9	53.9	24.0	48.3	46.5	1.8	98.7
North Dakota.....	13.7	9.7	4.0	6.3	4.5	1.8	7.4	5.2	2.2	8.4
Ohio.....	183.1	155.0	28.1	72.4	61.6	10.8	110.7	93.4	17.3	81.9
Oklahoma.....	130.4	105.2	25.2	92.8	70.5	22.3	37.6	34.7	2.9	35.7
Oregon.....	33.8	26.1	7.7	12.8	9.3	3.5	21.0	16.8	4.2	14.7
Pennsylvania.....	248.1	187.0	61.1	93.8	63.6	30.2	154.3	123.4	30.9	102.9
Rhode Island.....	25.4	19.1	6.3	5.7	5.2	.5	19.7	13.9	5.8	10.5
South Carolina.....	45.0	38.1	6.9	30.2	23.3	6.9	14.8	14.8	-----	56.7
South Dakota.....	14.2	11.0	3.2	4.9	4.2	.7	9.3	6.8	2.5	10.5
Tennessee.....	110.3	95.0	15.3	68.7	53.5	15.2	41.6	41.5	.1	75.6
Texas.....	283.9	240.2	43.7	221.3	178.0	43.3	62.6	62.2	.4	161.7
Utah.....	22.4	18.1	4.3	9.4	7.1	2.3	13.0	11.0	2.0	8.4
Vermont.....	12.2	8.8	3.4	5.6	4.3	1.3	6.6	4.5	2.1	4.2
Virginia.....	45.9	41.4	4.5	16.9	13.8	3.1	29.0	27.6	1.4	63.0
Washington.....	71.3	53.3	18.0	30.0	24.6	5.4	41.3	28.7	12.6	21.0
West Virginia.....	55.1	47.6	7.5	19.7	14.0	5.7	35.4	33.6	1.8	33.6
Wisconsin.....	73.7	50.5	23.2	28.1	19.3	8.8	45.6	31.2	14.4	33.6
Wyoming.....	5.8	4.4	1.4	2.9	2.1	.8	2.9	2.3	.6	2.1
Total.....	6,236.5	4,548.5	1,688.0	2,961.4	2,120.0	841.4	3,275.1	2,428.5	846.6	2,057.6

¹ Estimates include impact of 15-percent social security increase and \$4 "pass through" as well as effects of committee bill. Federal payments in family programs are the costs of FAP payments to current recipients (plus UF cases where States do not now have such programs) plus 30 percent of the estimated State supplements.

² Does not include estimated payments to the working poor.

³ These payments are very crudely estimated on the basis of the distribution of poverty among the States in 1960.

TABLE V.—SUMMARY OF COST CHANGES, CURRENT PROGRAMS VERSUS COMMITTEE BILL, CALENDAR YEAR 1968

[In billions of dollars]

	Total	Family programs	Adult programs
1. Actual 1968 costs:			
Total.....	5.4	2.8	2.6
Federal.....	3.2	1.5	1.7
State and local.....	2.2	1.3	.9
2. Estimated 1968 costs under committee bill:			
Total.....	8.3	5.3	3.0
Federal, subtotal.....	6.6	4.5	2.1
Recipients in present categories.....	4.5	2.4	2.1
"Working poor".....	2.1	2.1	
State and local.....	1.7	.8	.8
3. Changes in cost under committee bill:			
Total.....	2.9	2.5	.4
Federal, subtotal.....	3.4	3.0	.4
Recipients in present categories.....	1.3	.9	.4
"Working poor".....	2.1	2.1	
State and local.....	— .5	— .5	
4. Increased income of recipients under committee bill:			
Total.....	2.9	2.5	.4
Recipients in present categories.....	.8	.4	.4
"Working poor".....	2.1	2.1	

Note: Detail may not add due to rounding.

ALTERNATIVE BENEFIT LEVELS CONSIDERED

Your committee also considered the basic elements affecting the cost and coverage of plans like the family assistance plan. These elements are: (1) the amount of benefit provided to a family with no other income (the basic benefit level); (2) the rate at which this benefit level is reduced by the presence of earnings (the disregard formula or marginal tax rate); and (3) the level of family income at which it is no longer eligible for any benefit (the breakeven point). Any two of these elements determine the third.¹ They thus also determine the cost of the plan and the number of eligible families.

Raising the basic benefit level is consistent with the desire to provide more adequate support for those families who have no other means of support. Increasing it \$100, however, and keeping other parts of the family assistance plan the same, raises the family breakeven point by \$200, increases the cost by \$500 million and the number of eligible families by 300 thousand. The cost of such increases in general gets progressively higher; i.e. each additional \$100 in the basic benefit costs more than the preceding one. The costs and number of eligible families under plans otherwise identical to the family assistance plan, but with different basic benefit levels are shown below. The costs shown are gross costs and are not directly comparable to the net costs shown above.

¹ Actually, the basic benefit level and the breakeven point jointly determine only the average tax rate; a variable marginal tax rate, low in certain ranges of income and high in others, can be designed to produce any necessary average.

TABLE VI—ESTIMATED GROSS COSTS OF FAMILY ASSISTANCE PLAN AT DIFFERENT BENEFIT LEVELS,¹ CALENDAR YEAR 1968

[Dollars in billions]

Basic benefit level ²	Federal expenditures			State fiscal relief ³
	Total	Payments to families with children	30 percent matching of supplementals	
\$1,600.....	\$4.4	\$4.0	\$0.4	\$0.4
\$1,700.....	4.9	4.5	.4	.4
\$1,800.....	5.2	4.9	.3	.5
\$2,200.....	7.4	7.2	.2	.7
\$2,400.....	8.9	8.7	.2	.8
\$3,000.....	15.5	13.4	.1	1.0
\$3,600.....	20.7	20.7	.....	1.2

¹ Cost figures are for families with children only; i.e., they do not include costs of changes in adult categories. Administrative costs are not included.

² The proportion of the \$500 for the first two members to \$300 for additional members in the \$1,600 plan is maintained at the higher benefit levels.

³ Does not include fiscal relief from savings in general assistance programs.

Raising the marginal tax rate, thereby lowering the breakeven point, is consistent with the desire to reduce costs and prevent families with moderately higher incomes from becoming eligible for benefits. But it is inconsistent with the desire to provide positive financial incentives for work. For example, your committee's bill permits the first \$60 per month of earned income to be completely disregarded in determining a family's benefit under the family assistance plan. Deleting this particular provision would reduce the cost of the bill by \$840 million. Unfortunately, it would also produce many situations in which family heads would find themselves with less total disposable income when working than when not working. This is because expenses are incurred by going to work. In fact, the figure \$60 was chosen because it represents the average amount of work related expenses as determined by studies of the Department of Labor. Your committee finds that providing this disregard is necessary if appropriate work incentives are to be maintained. It also finds that providing a flat amount is preferable to existing law, which places no ceiling on the allowable deductions for work related expenses which States may permit in their current AFDC programs. Providing incentives for work is one thing; encouraging workers to take jobs which, in the absence of a family assistance or AFDC program, would yield them very little additional net income is quite another.

Your committee recognizes that there is little empirical information with which to decide precisely the appropriate marginal tax rate or benefit reduction formula. It is unfortunate that there is little more information today than there was when your committee was considering the 1967 amendments to the Social Security Act.

Beyond the basic disregard of \$60 a month, your committee's bill provides that family assistance benefits be reduced 50 cents for each additional dollar of earnings. State supplementary payments to families eligible for them will be reduced by 17 cents for each dollar of additional earnings, if the family is receiving family assistance benefits. The combined effect of the two reduction formulas is that families receiving both family assistance and State supplementary benefits will have their total benefits reduced by 67 cents for each dollar of earnings above \$60. Families whose incomes are sufficiently high that

they are no longer eligible for family assistance benefits but are still eligible for some State supplementary payment will have their benefits reduced 80 cents for each additional dollar of earnings above the family assistance break-even point.

EXTENSION OF FAMILY ASSISTANCE TO SINGLE ADULTS AND CHILDLESS COUPLES

Your committee investigated the cost and coverage implications of extending the family assistance plan concept to couples and unrelated individuals. With a basic benefit level of \$500 per year for a single individual and \$1,000 for a couple, family assistance gross payments would increase by \$1 billion and the number of persons covered by 4.5 million. Of course, net additional costs would be somewhat less, as the costs of the adult categories would decline. However, there would still have to be a substantial amount of Federal sharing of State supplementary payments within these categories, since the family assistance plan extended in this way would come nowhere near replacing the present Federal share of costs. (The present average annual Federal cost per OAA recipient is approximately \$565; under an extended family assistance plan concept, the average direct Federal payment would be less than \$300.) Further, every State would have to supplement the Federal payments to the aged, blind, and disabled because the maximum Federal payment to an individual with no other income would be \$41.66 per month. Because of the cost, and because no substantial improvements in the adult categories would be derived, your committee does not believe it wise to extend the family assistance plan concept to childless couples and unrelated individuals.

FINANCING ADULT ASSISTANCE PROGRAM

Your committee's bill does make several substantial improvements in the adult categories although it does not revise the basic nature of the program.

The administration had proposed a new Federal matching formula of 100 percent of the first \$50, 50 percent of the next \$15, and 25 percent thereafter (of the average payment per recipient). Your committee's bill proposes that the formula be 90 percent of the first \$65 and 25 percent thereafter. This increases the Federal cost by about \$30 million but prevents possible situations in which a State might make no contribution.

The administration had proposed a minimum income standard in the adult categories of \$90 per month per recipient. (A minimum income standard requires the State to make payments to individuals, which in combination with the individual's other income, equals the minimum standard.) Your committee's bill has a minimum income standard of \$110 a month per recipient.

It should be noted that the administration proposals were submitted prior to the recently enacted social security benefit increase. Since many of the recipients in the adult categories also receive social security benefit payments, changes in the latter program affect the Federal costs of public assistance. The savings due to the social security increase are estimated to be about \$100 million. These savings, along with other changes in the administration proposal, offset the increased cost of raising the minimum income standard.

Your committee explored the cost implications of minimum income standards above \$110 per month. It finds that they would require substantial additional Federal expenditures and require changes in the proposed Federal matching formula. The latter change would be necessary to protect the States from incurring costs that would not be offset by other provisions of your committee's bill¹. The cost implications of higher minimum income standards are shown below.

TABLE VII.—CHANGES IN ANNUAL FEDERAL AND STATE EXPENDITURES IN ADULT CATEGORY PROGRAMS FOR DIFFERENT MINIMUM INCOME STANDARDS, CALENDAR YEAR 1968

(In millions of dollars)

Minimum income standard	Change in expenditures ¹		
	Total	Federal	State and local
\$110.....	400	490	-90
\$120.....	600	540	60
\$130.....	820	600	220
\$140.....	1,060	660	400
\$150.....	1,310	720	590

¹ Federal share of average payments: 90 percent of the first \$65 and 25 percent thereafter.

FEDERAL CONTROL OF COSTS

Your committee has been concerned in recent years about the opened public assistance matching formula and the indications that the costs of the present welfare program, if the program is left unchanged, will continue to spiral upwards. The bill represents an effort to gain control over these ever-increasing costs. Under existing legislation, the Federal Government has virtually no control over welfare expenditures. This is especially true where States have elected to use the Federal matching formula provided by title XIX of the Social Security Act. Under that formula there is no limit on the extent to which the States can raise benefit levels or permit their caseloads to increase, and still receive 50 percent or higher Federal matching of their welfare costs. In contrast, substantial Federal control over welfare costs is achieved through three separate provisions of your committee's bill: (1) the basic benefit levels in the family assistance plan can only be changed by congressional action; (2) the Federal Government will only share in the States' supplementary payments that result from the use of a need standard at or below the poverty level; and (3) the Secretary of Health, Education, and Welfare can establish an upper limit to the Federal Government's matching of State costs in the adult category programs.

The Department of Health, Education, and Welfare has not provided detailed estimates of the costs of H.R. 16311 for periods later than calendar year 1968. (Procedures developed by the Department for estimating costs were devised during 1969 when the only available data was for 1968.) The Department has indicated that it will provide more current estimates as soon as possible. In the meantime, it is possible to indicate how the costs of public assistance might change under your committee's bill over time.

¹ The saving provision would, of course, protect the States. But at higher minimum income standards many more States would be eligible for reimbursement under this clause.

Under your committee's bill, the cost components of maintenance payments are different than under existing legislation. Family assistance gross payments are direct Federal payments to low-income families with children. In addition, there will be a 30-percent Federal matching of State supplementary payments. These two components constitute an approximate counterpart to the present Federal share of payments in the aid to families with dependent children program. Under your committee's bill, the Federal share of the adult category costs is more generous but otherwise unchanged.

Potential increases or decreases in these costs components are discussed below.

Total gross family assistance payments will be determined by the number of low-income families with children and their income other than assistance. With constant benefit levels, as population increases, costs increase; as incomes increase, costs decrease. If the earned income of the working poor continues to increase as it has in the past, the savings will more than offset the impact of increasing population. Preliminary studies of the Department of Health, Education, and Welfare indicate that gross payment costs are likely to decline at the annual rate of about \$70 to \$100 million per year. These estimates do not allow for the impact of the training programs, disincentive effects, a change in the rate of family breakup, or changes in the rate of unemployment.

The cost of the 30 percent Federal matching of State supplemental payments is likely to increase over time—barring an abrupt reversal of recent trends in public assistance. The Department of Health, Education, and Welfare has indicated that, were these trends to continue, this cost component would increase about \$120 to \$150 million per year.

The rate of increase in the costs of the adult categories is unlikely to be affected by your committee's bill. However, that rate would now be applied to a larger Federal share. Based on recent trends, the Department of Health, Education, and Welfare indicated that the Federal costs in the adult categories under your committee's bill are likely to increase about \$210 million per year. (The Secretary of Health, Education, and Welfare could place a ceiling on Federal participation in the adult categories. Such a ceiling would only affect a few States with high payments.)

A summary of potential annual changes in Federal costs under your committee's bill is shown below.

TABLE VIII.—*Potential annual changes in cost under committee bill*¹

<i>Item</i>	<i>Annual cost change (million)</i>
Reduced cost of family assistance plan gross payments.....	\$85
Increased cost of 30 percent Federal matching of State supplemental payments	135
Increased costs in adult category program.....	210
Total	260

¹ Assumes that the basic benefit level of \$500 for the first two family members and \$300 for each additional member in the family assistance plan remains unchanged. For illustrative purposes only, estimates also assume that present trends in public assistance are not changed by the provisions of H.R. 16311.

Under the Department's assumptions that (1) the recent growth in caseload and costs will continue unabated, (2) that the levels of family assistance payments will remain unchanged, and (3) that if the present

system were continued the States would be willing to pick up a larger share of these increased costs, the net additional costs of your committee's bill in 1975, as estimated by the Department, is shown in the following table:

TABLE IX.—POTENTIAL FEDERAL COSTS UNDER COMMITTEE BILL COMPARED TO EXISTING LEGISLATION, 1971-75¹

(In billions of dollars)					
	1971	1972	1973	1974	1975
Committee bill:					
Payments to families with children.....	3.8	3.8	3.7	3.6	3.5
30 percent matching of State supplementals.....	.8	.9	1.0	1.2	1.3
Subtotal.....	4.6	4.7	4.7	4.8	4.8
Federal share of adult category cost.....	2.7	2.9	3.2	3.4	3.6
Total.....	7.3	7.6	7.9	8.2	8.4
Existing legislation:					
Federal share of AFDC.....	2.5	2.9	3.4	3.9	4.5
Federal share of adult categories.....	2.0	2.3	2.5	2.7	2.8
Total.....	4.5	5.2	5.9	6.6	7.3

¹ Assumes that, with constant benefit levels, family assistance gross payment decline slightly. Other cost items are assumed to increase at the same rate as they have during the last 3 years (see discussion in text above).

Your committee believes that the additional restraints on State expenditures, a decrease in family breakup, increased activities to obtain support from parents, and the impact of work and training programs provided for in the bill will materially affect the present rapidly increasing costs of public assistance, thereby reducing the actual net additional costs somewhat below those shown above.

V. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill—the “Family Assistance Act of 1970”—and the table of contents.

TITLE I—FAMILY ASSISTANCE PLAN

SECTION 101. ESTABLISHMENT OF FAMILY ASSISTANCE PLAN

Section 101 of the bill amends title IV of the Social Security Act by adding parts D, E, and F to establish a new family assistance plan. Part D provides for the payment of family assistance benefits by the Secretary of Health, Education, and Welfare; part E provides for State supplementation of these benefits; and part F contains administrative provisions.

PART D—FAMILY ASSISTANCE PLAN

SECTION 441. APPROPRIATIONS

Section 441 authorizes the appropriation each year of a sum sufficient to carry out part D, for the purpose of providing a basic level of financial assistance throughout the Nation to needy families with children in a manner which will strengthen family life, encourage work training and self-support, and enhance personal dignity.

SECTION 442. ELIGIBILITY FOR AND AMOUNT OF FAMILY ASSISTANCE BENEFITS

Eligibility

Section 442(a) provides that each family (as defined in section 445) whose income other than that excluded under section 443(b) is less than \$500 per year for each of the first two family members plus \$300 per year for each additional member, and whose resources other than those excluded under section 444 are less than \$1,500, will be paid a family assistance benefit.

Amount

Section 442(b) provides that the amount of the family assistance benefit is \$500 per year for each of the first two family members plus \$300 per year for each additional member, reduced by the amount of the family's income not excluded under section 443(b).

Period for determination of benefits

Section 442(c)(1) provides that a family's eligibility for family assistance benefits, and the amount of such benefits, is to be determined for each calendar quarter by the Secretary of Health, Education, and Welfare on the basis of his estimates of the family's income for such quarter, taking into account income for an earlier period and any likely changes in conditions which would affect the family's eligibility or the amount of the benefits. Redeterminations for any quarter are to be made at such times as the Secretary may prescribe, effective prospectively.

Section 442(c)(2) provides that the Secretary may reduce a family's assistance benefits for a quarter if the family files its application for such benefits after that quarter begins.

Section 442(c)(3) provides that the Secretary may, for purposes of determining eligibility for and amount of family assistance benefits, consider income actually received in one period (or expenses incurred in earning income in one period) to have been received (or incurred) in another.

Special limits on gross income

Section 442(d) provides that the Secretary by regulation may prescribe circumstances under which gross income from a trade or business (including farming) is large enough to preclude eligibility for family assistance benefits.

Puerto Rico, the Virgin Islands, and Guam

Section 442(e) is a cross-reference to section 1108(e) of the Act (as added by section 403 of the bill), which sets out the special method by which family assistance benefits are to be determined for families in Puerto Rico, the Virgin Islands, and Guam.

SECTION 443. INCOME

Meaning of income

Section 443(a) provides that, for purposes of the family assistance benefit program, income means both earned and unearned income.

(1) Earned income is defined in paragraph (1) as—

(A) remuneration from employment (i.e., remuneration for services performed as an employee (as defined in section 210(j) of the Act)), but excluding—

(i) payments (described in section 209(b) of the Act) made to an employee or his family on account of retirement, sickness, or accident, medical or hospital expenses, or death, under a plan or system, and payments on an employee's behalf into such a system (with the payments being counted as unearned income when made to the employee or his family out of the plan or system, but not being counted as either earned or unearned income when made by the employer into the plan or system),

(ii) payments (described in section 209(c)) made to an employee on account of retirement but not under a plan or system,

(iii) payments (described in section 209(d)) made on account of sickness or accident disability, or medical or hospital expenses in connection with sickness or accident disability, not under a plan or system, after the six calendar months following the month in which the employee last worked (with payments during the first six months being counted as earned income),

(iv) payments (described in section 209(f)) made by an employer for unemployment compensation,

(v) payments (described in section 209(k)) made by an employer on account of moving expenses of an employee,

(vi) payments for certain services actually performed as an employee but treated as self-employment; and

(B) net earnings from self-employment as defined in section 211 of the Act (except for that part of section 211 which deals with the optional definition of net earnings from farming), including certain services performed by ministers, Christian Science practitioners, and members of religious orders, and by certain members of religious faiths who have received an exemption from coverage.

(2) Unearned income is defined in paragraph (2) as all income other than earned income (as defined in paragraph (1)), including specifically any payments received as annuity, pension, retirement, or disability benefits, veterans' or workmen's compensation, old-age, survivors, and disability insurance benefits, railroad retirement benefits, unemployment benefits, prizes, awards, life insurance policy proceeds, gifts (cash or otherwise), support and alimony payments, inheritances, rents, dividends, interest, and royalties.

Exclusions from income

Section 443(b) provides that the following are to be excluded in determining a family's income:

(1) Earned income of a child regularly attending school, subject to limitations (as to amount or otherwise) prescribed by the Secretary of Health, Education, and Welfare;

(2) the total unearned income of the family in a calendar quarter which (as determined under criteria prescribed by the Secretary) is received too infrequently or irregularly to be included, if such unearned income does not exceed \$30 in the quarter, and the total earned income of the family in a calendar quarter which (as determined under such criteria) is received too irregularly or infrequently to be included, if such earned income does not exceed \$30 in the quarter;

(3) part or all of any earned income which (under regulations prescribed by the Secretary) is necessary to pay the cost of child care so that the family member incurring such cost can participate in manpower training, vocational rehabilitation, employment, or self-employment;

(4) the first \$720 a year (or proportionately smaller amounts for shorter periods) of the total earned income (not previously excluded) of all family members plus one-half of the remainder;

(5) food stamps or other assistance (not including veterans' pensions) which is based on need and is furnished by a State or locality or a Federal agency, or by a private charitable organization (as determined by the Secretary);

(6) the training and other allowances provided under the new section 432(a) (discussed below);

(7) the tuition and fees portion of any scholarship or fellowship at an educational institution; and

(8) home produce produced and used by the family.

SECTION 444. RESOURCES

Exclusions from resources

Section 444(a) provides that, in determining a family's resources, its home, household goods, and personal property are to be excluded, along with any other property which the Secretary of Health, Education, and Welfare determines by regulation is essential to the family's means of self-support.

Disposition of resources

Section 444(b) directs the Secretary, by regulation, to prescribe the period or periods within which, and the manner in which, a family's property must be disposed of in order not to be included in determining the family's eligibility for family assistance benefits. Any benefits paid during such a period are to be conditioned on such disposal and considered overpayments (and therefore recoverable) to the extent that they would not have been paid had the disposal occurred at the beginning of the period for which the benefits were paid.

SECTION 445. MEANING OF FAMILY AND CHILD

Composition of family

Section 445(a) defines a family (for purposes of parts A, C, and E as well as the family assistance benefit program) as two or more people who are related by blood, marriage, or adoption and who are residents of the United States living together in a place of residence maintained as a home by one or more of them. At least one of the family members must be a child who is not married to another family member and who is in the care of, or dependent upon, another family member. A parent (of a child living in the place of residence), or a spouse of such a parent, who is determined by the Secretary of Health, Education, and Welfare to be temporarily absent from the place of residence in order to engage in or seek employment or while he is in the military service is to be considered as living in the residence.

Definition of child

Section 445(b) defines a child (for purposes of parts C and E as well as the family assistance benefit program) as an individual who is under

age 18, or is under age 21 and (as determined by the Secretary under regulations) a student regularly attending a school, college, or university or a course of training in preparation for employment.

Determination of family relationships

Section 445(c) provides that in determining whether two individuals are related by blood, marriage, or adoption, appropriate State law is to be applied.

Income and resources of noncontributing individual

Section 445(d) provides that the income and resources of an individual other than a parent or the spouse of a parent which (as determined under criteria prescribed by the Secretary) is not available to other members of the family is to be excluded in determining the family's eligibility for and amount of benefits, and an individual (other than such a parent or spouse) any of whose income and resources is not available to a family will not be considered a member of the family (except that if such individual is a child who would otherwise be considered a member of the family, he will be considered a member of the family for purposes of determining the family's eligibility (but not the amount of its benefit)).

Recipients of aid to the aged, blind, and disabled ineligible

Section 445(e) provides that an individual who is receiving aid to the aged, blind, and disabled under a State plan approved under title XVI of the Act (as amended by section 201 of the bill), or whose needs are taken into account in determining the need of another individual receiving such aid, will not be considered a member of a family for purposes of determining the amount of the family's benefits.

SECTION 446. PAYMENTS AND PROCEDURES

Payments of benefits

Section 446(a)(1) provides that family assistance benefits are to be paid at such times and in such installments as the Secretary of Health, Education, and Welfare determines.

Section 446(a)(2) provides that a family's benefits may be paid to any one or more family members, or (on behalf of the family, if the Secretary deems it appropriate) to another person who is interested in or concerned with the family's welfare.

Section 446(a)(3) allows the Secretary to prescribe regulations establishing ranges of incomes within which single amounts of family assistance benefits will apply.

Overpayments and underpayments

Section 446(b) provides that when more or less than the correct amount of family assistance benefits has been paid to a family the Secretary will make proper adjustments by increases or decreases future payments or by recovery from or payment to one or more individuals who are or were members of the family, with appropriate provision to avoid penalizing family members who were without fault if adjustment or recovery would defeat the purpose of the program, be against equity or good conscience, or impede efficient or effective administration.

Hearings and review

Section 446(c)(1) provides that the Secretary will furnish reasonable notice and opportunity for a hearing to any person who is or claims to be a family member and is in disagreement with a determination on eligibility for family assistance benefits, the amount of the benefits, or the number of persons in the family, if a request for such hearing is made within thirty days after notice of the determination is received. If payments of benefits are already being made to the family, they will be continued until a determination is made on the basis of the hearing (or the claim is otherwise disposed of), but any benefits so paid will be considered overpayments (and therefore recoverable) if the determination is that they were incorrectly paid.

Section 446(c)(2) provides that a determination by the Secretary must be made within ninety days after the individual requests the hearing.

Section 446(c)(3) provides that a final determination by the Secretary after a hearing will be subject to judicial review as provided under section 205(g) of the Act except that all determinations of fact on the basis of such hearing will be conclusive and not subject to review by any court.

Procedures; prohibition of assignments

Section 446(d) provides that sections 206 and 207 of the Act, and subsections (a), (d), (e), and (f) of section 205 of the Act, will apply with respect to family assistance benefits the same as they apply to OASDI benefits. Section 206 of the Act authorizes the Secretary to prescribe rules and regulations governing representation of claimants and to prescribe maximum fees which may be charged for services performed in connection with any claim. Section 207 of the Act provides that the right of any person to future payments will not be transferable or assignable or subject to execution, levy, attachment, garnishment, or other legal process. Subsections (a), (d), (e), and (f) of section 205 of the Act give the Secretary the authority to make rules and regulations concerning evidence and the submission thereof, and to issue subpoenas for the purpose of any hearing, investigation, or other procedure.

Applications and furnishing of information by families

Section 446(e)(1) provides that the Secretary is to prescribe regulations with respect to the filing of applications, the furnishing of information, and the reporting of events and circumstances, as necessary to determine eligibility for and amount of family assistance benefits.

Section 446(e)(2) provides that in order to encourage prompt reporting of events and circumstances relevant to eligibility for and amount of benefits and more accurate estimates of expected income or expenses the Secretary may treat as overpayments all or part of any payments made for a period during which there was a failure or delay in reporting, or inaccurate reporting of information on which the estimates of income or expenses were based.

Furnishing of information by other agencies

Section 446(f) provides that the head of any Federal agency is to furnish the Secretary any information needed for determining eligi-

bility for or amount of family assistance benefits or for verifying other information.

SECTION 447. REGISTRATION AND REFERRAL OF FAMILY MEMBERS FOR
MANPOWER SERVICES, TRAINING, AND EMPLOYMENT

Section 447(a) provides that every individual who is a member of an eligible family and who is not excepted by section 447(b) must register with the local State public employment office for manpower services, training, and employment as provided by regulations of the Secretary of Labor. If and for so long as any individual fails to register as required, he will not be considered a family member for purposes of determining his family's eligibility for or amount of benefits but his income will be counted as family income in the regular way; except that if he is the only family member other than a child he will be considered a family member for purposes of determining the family's eligibility for benefits (but not their amount). No part of any family assistance benefit may be paid to any individual who fails to register for manpower services, training, or employment as required; but the Secretary may, if he deems appropriate, pay the benefits due the family to any person, other than a member of the family, who is interested in or concerned with the welfare of the family.

Section 447(b) provides that an individual will not be required to register for manpower services, training, or employment if the Secretary determines that such individual is (1) unable to engage in work or training by reason of illness, incapacity, or advanced age, (2) a mother or other relative of a child under the age of six who is caring for such child, (3) the mother or other female caretaker of a child, if the father or another adult male relative is in the home and is not otherwise exempted from the requirement of registration, so long as such father or other adult male relative has not refused to register or to participate in work or training, (4) a child under age 16 or in school, or (5) one whose presence in the home is required because of the illness or incapacity of another member of the household. An individual who is not required to register for manpower services, training, or employment may nevertheless register if he so desires.

Section 447(c) directs the Secretary in all appropriate cases to make provision for furnishing child care services for individuals registered for or participating in manpower services, training, employment, or vocational rehabilitation under the program.

Section 447(d) provides that the Secretary will refer to the appropriate State agency for vocational rehabilitation services any individual who is a family member and who is not required to register for manpower services, training, or employment because of incapacity. Review of such individual's incapacity and need for rehabilitation services will be made as necessary (except for individuals determined to be permanently and totally disabled) but not less often than quarterly. If the individual refuses without good cause to accept rehabilitation services, he will be treated as though he were an individual who refused to register for manpower services, training, or employment when required to do so.

SECTION 448. DENIAL OF BENEFITS IN CASE OF REFUSAL OF MANPOWER SERVICES, TRAINING, OR EMPLOYMENT

Section 448(a) provides that any individual who is a family member and has registered for manpower services, training, or employment pursuant to section 447 but who refuses without good cause (as determined after a hearing by the Secretary of Labor, whose decision is final and nonreviewable) to participate in suitable manpower services, training, or employment will not be considered a family member for purposes of determining his family's eligibility for or amount of benefits but his income will be counted as family income in the regular way; except that if he is the only family member other than a child he will be considered a family member for purposes of determining the family's eligibility for benefits (but not their amount). No part of any family assistance benefit may be paid to any individual during a period when he has without good cause refused manpower services, training, or suitable employment as required; but the Secretary may, if he deems appropriate, pay the benefits due the family to any person, other than a member of the family, who is interested in or concerned with the welfare of the family.

Section 448(b) provides that in determining whether employment is suitable for an individual (for purposes of part C (relating to manpower services, training, employment, etc.)), as well as for purposes of section 448(a)), the Secretary of Labor will consider the degree of risk to the individual's health and safety, his physical fitness for the work, his prior training, experience, and earnings, the length of his unemployment, his prospects for obtaining work based upon his potential and the availability of training opportunities, and the distance of the available work from his residence. In addition, employment is not to be considered suitable for an individual (1) if the job offered is vacant due to a labor dispute, (2) if the wages, hours, or other conditions of the work offered are contrary to or less than those prescribed by law or substantially less favorable than those prevailing for similar work in the locality, or (3) if, as a condition of employment, the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization.

SECTION 449. TRANSFER OF FUNDS FOR ON-THE-JOB TRAINING PROGRAMS

Section 449 provides that the Secretary of Health, Education, and Welfare will to the extent provided by agreement with the Secretary of Labor pay to the Secretary of Labor such amounts as would be paid as family assistance benefits to individuals participating in public or private employer-compensated on-the-job training programs if such individuals were not participating in such training. Sums so paid to the Secretary of Labor will be available to pay the costs of such on-the-job training programs.

PART E—STATE SUPPLEMENTATION OF FAMILY ASSISTANCE BENEFITS

SECTION 451. PAYMENTS UNDER TITLES IV, V, XVI, AND XIX
CONDITIONED ON SUPPLEMENTATION

Section 451 provides that a State must enter into an agreement with the Secretary of Health, Education, and Welfare to supplement the

family assistance payments made under part D of title IV in order to become or remain eligible for Federal payments under part A (services to needy families with children) and part B (child-welfare services) of such title, or under title V (maternal and child health, and crippled children's services), title XVI (aid to the aged, blind, and disabled), or title XIX (medical assistance), except in the case of the working poor—i.e., except in the case of families where both parents are present, neither is incapacitated, and the father is not unemployed.

SECTION 452. ELIGIBILITY FOR AND AMOUNT OF SUPPLEMENTARY PAYMENTS

Section 452(a) provides that eligibility for and the amount of a State's supplementary payments will be determined generally under the rules and regulations applicable to the Federal family assistance payments and by applying the State's standard of need and payment limitations as in effect (and in compliance with the requirements of part A) in January 1970, unless the State chooses to apply a higher standard; except that supplementary payments are not required in any case above the applicable poverty level determined under section 453(c) (discussed below). The resulting amount is to be reduced by the family assistance payment (if any) and by any income not excluded under section 443(b) (except for the first \$720 a year of the family's earned income and one-half of its remaining earned income) or under section 452(b). Any limitations imposed by the State on the amount of aid paid must not (in combination with the other plan provisions) be more stringent in result than those in effect in January 1970. If the State plan provides for meeting less than 100 percent of its need standard or for considering less than 100 percent of requirements in determining need, the Secretary will by regulation prescribe the method to be used to ensure that these results are achieved.

Section 452(b) provides that in computing the amount of a family's supplementary payments, a State will disregard (1) \$720 of the family's earned income, plus (2) one-third of its earned income between \$720 and twice the amount of its family assistance benefit prior to any reduction for income, plus (3) at least one-fifth of any remaining earned income.

Section 452(c) requires that a State agreement for payment of supplementary benefits must provide for—

- (1) statewide application of the agreement,
- (2) administration or supervision by a single State agency,
- (3) an opportunity for a fair hearing before the State agency for any individual whose claim is denied or is not promptly acted upon,
- (4) methods of administration necessary for the proper and efficient operation of the State agreement, and training and effective use of a paid subprofessional staff with emphasis on employment of recipients of supplementary payments,
- (5) reporting to the Secretary as required,
- (6) safeguards to protect the confidentiality of information, and
- (7) an opportunity for all to apply for benefits, and payments with reasonable promptness.

SECTION 453. PAYMENTS TO STATES

Section 453(a)(1) provides that the Secretary of Health, Education, and Welfare will pay each State 30 percent of the amount expended by it each fiscal year for supplementary payments, not counting that part of such payment to any family which exceeds the difference between (A) the applicable poverty level (determined under section 453(c)) and (B) the family assistance benefit payable to the family plus any income of the family not disregarded in computing the supplementary payment.

Section 453(a)(2) provides that the Secretary will pay each State one-half of its administrative costs incurred in carrying out the agreement for supplementary payments.

Section 453(b) provides that payments to States under section 453(a) will be made at such times and in such installments as the Secretary determines.

Section 453(c)(1) provides that the "poverty level" for a family of any given size is the amount shown for a family of that size in the following table, adjusted as provided in section 453(c)(2):

<i>Family size</i>	<i>Basic amount</i>
One.....	\$1, 920
Two.....	2, 460
Three.....	2, 940
Four.....	3, 720
Five.....	4, 440
Six.....	4, 980
Seven or more.....	6, 120

Section 453(c)(2) provides that between July 1 and September 30 of each year (beginning with 1970) the Secretary is to adjust the amount shown for each size of family in the table by increasing such amount by the percentage by which the average level of the price index for the second calendar quarter of such year exceeds the average level of the price index for months in 1969, and is to promulgate the adjusted amounts as the poverty levels for families of various sizes. The new amounts will apply for the fiscal year beginning July 1 after such promulgation.

Section 453(c)(3) defines the term "price index" to mean the Consumer Price Index (all items—United States city average) published monthly by the Bureau of Labor Statistics.

SECTION 454. FAILURE BY STATE TO COMPLY WITH AGREEMENT

Section 454 provides that the Secretary of Health, Education, and Welfare may withhold all or an appropriate part of the payments he would otherwise make to a State if, after notice and opportunity for a hearing, he finds the State is failing to comply with its agreement.

PART F—ADMINISTRATION

SECTION 461. AGREEMENTS WITH STATES

Section 461(a) provides that the Secretary of Health, Education, and Welfare may enter into an agreement with any State to make the supplementary payments on its behalf, or perform functions related to the making of such payments, or both. The State would pay the Secretary the amount of the supplementary payments less

the Federal share of such payments under section 453(a), and could request joint audit of such payments.

Section 461(b) provides that the Secretary may enter into an agreement with any State under which the State will make family assistance payments on behalf of the Secretary with respect to all or specified families in the State, or perform other functions as agreed upon. The State would be paid the cost of carrying out the agreement.

SECTION 462. PENALTIES FOR FRAUD

Section 462 provides penalties for fraud, with respect to family assistance benefits and supplementary payments, similar to those provided in section 208 of the Act with respect to OASDI benefits.

SECTION 463. REPORT, EVALUATION, RESEARCH AND DEMONSTRATIONS, AND TRAINING AND TECHNICAL ASSISTANCE

Section 463(a) provides that the Secretary of Health, Education, and Welfare is to make an annual report to the President and the Congress on the operation of the family assistance benefit and supplementary payment programs.

Section 463(b) authorizes the Secretary to conduct research and experiments to determine better ways of providing financial assistance to needy persons, waiving the requirements of the family assistance program to the extent he deems it appropriate.

Section 463(c) authorizes the Secretary to provide technical assistance to the States, and training for State personnel, to assist the States in carrying out their supplementary payment programs.

Section 463(d) places a limitation of \$20 million per fiscal year (from amounts appropriated for the family assistance benefit and supplementary payment programs) on the funds which may be used in carrying out this section.

SECTION 464. OBLIGATION OF DESERTING PARENTS

Section 464 provides that receipt of family assistance benefits or State supplementary payments by the spouse or children of a deserting parent during his absence will result in a monetary obligation to the United States by the deserting parent equal to the total amount of the family assistance benefits received by the deserting parent's spouse and children plus any amount paid to the State under section 453. The deserting parent's obligation is reduced by any payments which he actually makes to his family during the period and which are excluded in computing the family assistance benefits paid to his spouse and children; and in no case would his obligation exceed the amount (if any) ordered by a court of competent jurisdiction for the support and maintenance of his spouse or children, less any payments made under such order. The amount due the United States is to be collected from any amounts otherwise due or becoming due the deserting parent from any officer or agency of the United States or under any Federal program. (Under the amendments made by section 103(b)(1)(K), (O), and (P) of the bill, the existing State-Federal arrangements for locating deserting parents and obtaining support for their families, under the program of services to needy families with children, are expanded to take account of deserted spouses as well as children.)

**SECTION 465. TREATMENT OF FAMILY ASSISTANCE BENEFITS AS INCOME
FOR FOOD STAMP PURPOSES**

Section 465 provides that family assistance benefits will be taken into consideration for purpose of determining any household's entitlement to, and the cost of, food stamps under the Food Stamp Act of 1964.

**SECTION 102. MANPOWER SERVICES, TRAINING, EM-
PLOYMENT, CHILD CARE, AND SUPPORTIVE SERVICES
PROGRAMS**

Section 102 of the bill completely rewrites part C of title IV of the Social Security Act to provide new programs of manpower services, training, employment, child care, and related supportive services for members of families receiving family assistance benefits or supplementary payments under part D or part E of such title.

**PART C—MANPOWER SERVICES, TRAINING, EMPLOYMENT, CHILD
CARE, AND SUPPORTIVE SERVICES PROGRAMS FOR RECIPIENTS OF
FAMILY ASSISTANCE BENEFITS OR SUPPLEMENTARY PAYMENTS**

SECTION 430. PURPOSE

Section 430 sets forth the purpose of the revised part C—to provide programs and services for recipients of family assistance benefits or supplementary payments in order to train them, prepare them for employment, and otherwise assist them in securing and retaining regular employment with opportunity for advancement so that needy families with children will be restored to self-supporting, independent, and useful roles in their communities.

**SECTION 431. OPERATION OF MANPOWER SERVICES, TRAINING, AND
EMPLOYMENT PROGRAMS**

Section 431(a) provides that the Secretary of Labor is to develop an employability plan for each person registered under the family assistance benefits program (part D of title IV of the Act), in order to enable him to secure employment and remain self-supporting.

Section 431(b) provides that the Secretary of Labor is to establish and maintain manpower services, training, and employment programs in each State for persons registered under the family assistance benefits program and persons receiving State supplementary payments under part E of title IV.

Section 431(c) provides for the establishment of such manpower services, training, and employment programs as are necessary to carry out the purpose of part C, including (1) any services which the Secretary is authorized to provide under any other Act; (2) counseling, testing, training, work experience, and job placement; (3) relocation assistance to aid unemployed individuals in relocating in areas where there is assurance of suitable employment (offered through public employment offices) which will lead to self-support without public assistance; and (4) special work projects.

Section 431(d) defines a "special work project" as a project which consists of the performance of work in the public interest through

grants to or contracts with public or nonprofit private agencies or organizations. Wage rates for special work projects cannot be lower than the applicable minimum wage for the particular work concerned; appropriate health and safety standards are to be maintained; the project must not displace employed workers; the conditions of work, training, education, and employment must be reasonable from the standpoint of the type of work, the geographic location, and the proficiency of the participant; workmen's compensation protection must be provided; and the project must improve the employability of the participants. The Secretary of Labor must, at least every six months, review each participant's employment record and any other pertinent information and determine whether it would be feasible to place him in regular employment or in training.

SECTION 432. ALLOWANCES FOR INDIVIDUALS UNDERGOING TRAINING

Section 432(a)(1) directs the Secretary of Labor to pay each participant in manpower training under the revised part C an incentive allowance of \$30 per month or, if greater (in a case where the participant is eligible for a training allowance under section 203 of the Manpower Development and Training Act), the difference between the sum of the participant's family assistance benefits and supplementary payments under parts D and E and the amount of such training allowance (or so much thereof as does not exceed the training allowance which would be payable under such section 203 as in effect on March 1, 1970).

Section 432(a)(2) provides that the Secretary of Labor is to pay, to any participant in manpower training under part C, allowances for transportation and other expenses necessary for and directly related to such training.

Section 432(a)(3) provides that the Secretary of Labor by regulation is to provide for such smaller allowances as he deems appropriate for participants in manpower training in Puerto Rico, the Virgin Islands, and Guam.

Section 432(b) provides that allowances under section 432(a) are to be in lieu of allowances provided under any manpower training program under any other Act.

Section 432(c) provides that allowances under section 432(a) will not be payable to any person who is participating in a program sponsored by the Secretary of Labor providing public or private employer-compensated on-the-job training.

SECTION 433. UTILIZATION OF OTHER PROGRAMS

Section 433 authorizes the Secretary of Labor, using all authority granted to him under any other Act, to provide the manpower training and employment services required by the revised part C in such manner as will make maximum use of existing manpower programs and agencies and will further the establishment of an integrated and comprehensive manpower training program; and to use the funds appropriated under part C to provide the required programs through such other Acts and to reimburse public and private agencies for services rendered to persons under part C when such services are not otherwise available on a nonreimbursable basis.

SECTION 434. RULES AND REGULATIONS

Section 434 authorizes the Secretary of Labor to issue such rules and regulations as he finds necessary to carry out the purposes of the revised part C.

SECTION 435. APPROPRIATIONS; NONFEDERAL SHARE

Section 435(a) provides that funds sufficient to carry out the purposes of the revised part C (other than the funds required for child care and supportive services) are authorized to be appropriated to the Secretary of Labor each year, including funds for payment of up to 90 percent of the cost of providing manpower services, training, and employment for persons registered under the family assistance program. The Secretary of Labor is to establish criteria to achieve equitable apportionment among the States of Federal expenditures for the programs of manpower services, training, and employment which are authorized under section 431.

Section 435(b) provides that if a State fails to contribute its 10-percent share of the cost of manpower services, training, and employment provided for individuals under the family assistance program who are registered under section 447, the Secretary of Health, Education, and Welfare may, after notice and opportunity for hearing, withhold payments which would otherwise be made to the State under sections 403(a) (services to needy families with children), 453 (State supplementary payments (discussed above)), 1604 (aid to the aged, blind or disabled (discussed below)), and 1903(a) (medical assistance) until the amount withheld, less any contribution made by the State, equals such 10-percent share. (Under the amendment made by section 103(b)(1)(M) of the bill, this 10-percent State contribution must be required by the State's plan for services for needy families with children under part A of title IV of the Act.)

SECTION 436. CHILD CARE

Section 436(a)(1) authorizes the appropriation each year to the Secretary of Health, Education, and Welfare of sufficient funds to enable him to make grants to public and nonprofit private agencies and organizations and contracts with public and private agencies and organizations to cover part or all (100 percent) of the cost of projects for the provision of child care to permit individuals registered or referred for vocational rehabilitation under part D or receiving supplementary payments under part E to undertake or continue manpower training or employment under the revised part C, or to permit individuals who are or have been eligible for payments under part D or part E to undertake or continue manpower training or employment under the revised part C, or, with respect to the period prior to the date part D becomes effective, to permit individuals who are receiving aid to families with dependent children (or whose needs are taken into account in determining the need of persons claiming or receiving such aid) to participate in manpower training or employment.

Section 436(a)(2) provides that the grants or contracts made under section 436(a)(1) may be made directly or through grants to a public or nonprofit private agency, designated by the appropriate elected

or appointed official or officials in the area, which will work with the local manpower agency. To the extent appropriate, the arrangements are to be made with the local educational agency to provide care for children attending school.

Section 436(a)(3) provides that various types of child care will be provided, based upon the needs and circumstances of the children involved.

Section 436(b) provides that the Secretary may use sums appropriated under section 436(a)(1) to make grants to any public or private nonprofit agency or organization, or contracts with any private or public agency or organization, for evaluation, training of personnel, technical assistance, or research and demonstration projects to determine more effective methods of providing child care.

Section 436(c) provides that the Secretary may establish reasonable fees for the child care provided for any family that is able to pay for part or all of the cost thereof.

SECTION 437. SUPPORTIVE SERVICES

Section 437(a) provides that no payments will be made to a State under title V (maternal and child health and crippled children's services), title XVI (aid to the aged, blind, and disabled), title XIX (medical assistance), or part A or B of title IV for expenditures for any calendar quarter beginning on or after the date the family assistance program becomes effective, unless such State has an agreement with the Secretary of Health, Education, and Welfare under which it will provide health, counseling, social, vocational rehabilitation, and other supportive services which the Secretary determines are necessary to permit an individual registered under part D or receiving supplementary payments under part E to undertake or continue manpower training and employment.

Section 437(b) provides that the supportive services required under section 437(a) are to be furnished in cooperation with the manpower training and employment services provided under the revised part C.

Section 437(c) provides for payments to a State, at such times and in such installments as are deemed appropriate by the Secretary, of up to 90 percent of the cost of the supportive services provided by the State under its agreement under section 437(a).

SECTION 438. ADVANCE FUNDING

Section 438(a) provides that appropriations for grants, contracts, and other payments under the revised part C with respect to persons registered under part D may be included in the appropriation Act for the fiscal year preceding the fiscal year for which they are to be used.

Section 438(b) provides that in order to effect a transition to the advance funding procedure two separate appropriations may initially be made in the same fiscal year, one for that year and one for the following fiscal year.

SECTION 439. EVALUATION AND RESEARCH: REPORTS TO CONGRESS

Section 439(a)(1) provides that the Secretary of Labor and the Secretary of Health, Education, and Welfare will jointly make provi-

sion for continuing evaluation of manpower training and employment programs provided under the revised part C, and that the Secretary of Labor may conduct research and establish demonstration projects regarding ways to improve the effectiveness of manpower training and employment programs, contract for independent evaluations and research regarding such programs, and establish a system for collection, processing, and retrieval of data.

Section 439(a)(2) authorizes the appropriation, for the costs of the evaluation and research provided for in section 439(a)(1), of up to \$15,000,000 for any fiscal year.

Section 439(b) provides that on or before September 1 following each fiscal year the Secretary of Labor is to report to the Congress on the manpower training and employment programs provided under the revised part C, and the Secretary of Health, Education, and Welfare is to report to the Congress on the programs of child care and supportive services provided under such part.

SECTION 103. CONFORMING AMENDMENTS RELATING TO ASSISTANCE FOR NEEDY FAMILIES WITH CHILDREN

Section 103 of the bill extensively amends part A of title IV of the Social Security Act—the present program of aid to families with dependent children—to eliminate all money payments; under the bill cash payments to needy families with children are to be made under the new family assistance program (part D) with State supplementation (part E), and the social and other services which are necessary or appropriate for such families are to be provided under State plans approved under part A.

Except for the changes which are necessary to conform the requirements and conditions of part A to those included in parts D and E (e.g., the definitions of applicable terms) and the changes referred to above in the discussion of sections 464 and 435(b), the provisions of this section are designed solely to make the amendments required to eliminate money payments from part A programs and the technical, clerical, and conforming changes necessitated by those amendments.

TITLE II—AID TO THE AGED, BLIND, AND DISABLED

SECTION 201. GRANTS TO STATES FOR AID TO THE AGED, BLIND, AND DISABLED

Section 201 of the bill completely rewrites title XVI of the Social Security Act, which provides for grants to States for aid to the aged, blind, and disabled.

TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, AND DISABLED

SECTION 1601. APPROPRIATIONS

Section 1601 authorizes appropriations for the purpose of enabling each State, under a State plan approved under section 1602, to furnish

financial assistance to needy individuals who are 65 years of age or over, blind, or disabled and for the purpose of encouraging each State (under such plan) to furnish rehabilitation and other services to help such individuals attain or retain capability for self-support or self-care.

SECTION 1602. STATE PLANS FOR FINANCIAL ASSISTANCE AND SERVICES TO THE AGED, BLIND, AND DISABLED

Section 1602(a) provides that an approved State plan for aid to the aged, blind, and disabled must provide for—

(1) a single State agency to administer (or supervise the administration of) the plan;

(2) administrative methods necessary for the proper and efficient operation of the plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis;

(3) the training and effective use of social service personnel, technical assistance to units of State and local government which are furnishing financial assistance or services to the aged, blind, and disabled, and the development through research or demonstration projects of new and improved methods of furnishing such assistance or services;

(4) the training and effective use of paid subprofessional staff (including recipients and others of low income), and the use of nonpaid or partially paid social service volunteers;

(5) opportunity to apply for aid and the assurance of its prompt payment;

(6) the use of a simplified statement, as prescribed by the Secretary, to establish eligibility, with effective methods for verifying eligibility through use of sampling and other scientific techniques;

(7) Statewide application of the plan, with the exception of services to the extent prescribed by the Secretary;

(8) financial participation by the State;

(9) the determination of blindness either by a physician skilled in diseases of the eye or by an optometrist, whichever the individual selects;

(10) an opportunity for a fair hearing before the State agency for individuals whose claims for aid under the plan are denied or are not acted upon with reasonable promptness;

(11) an evaluation (at least annually) of the operation of the plan, under standards prescribed by the Secretary, with reports to the Secretary including any planned modifications;

(12) reports to be made as the Secretary requires;

(13) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(14) the designation of a State authority to be responsible for standards for public or private institutions if the plan includes aid to or on behalf of individuals in such institutions;

(15) description of the services which the State makes available to applicants or recipients of aid under the plan to help them attain self-support or self-care; and

(16) agreement by administering States to observe priorities established by the Secretary and comply with performance standards established by the Secretary.

Section 1602(a) permits a State (notwithstanding paragraph (1)) to designate the State agency which previously administered or supervised the administration of the State's plan for aid to the blind approved under title X as the agency to administer or supervise the administration of that portion of the State plan for aid to the aged, blind, and disabled which relates to blind individuals, if on January 1, 1962, and on the date in which such State submits its plan for approval under the revised title XVI, the State's title X agency was different from the State agency or agencies that administered or supervised the administration of the State plans approved under title I (old-age assistance) and title XIV (aid to the permanently and totally disabled). In such a case, the part of the plan which each agency administers or supervises is to be regarded as a separate plan.

Section 1602(b) directs the Secretary to approve any plan which fulfills the conditions in section 1602(a) and the provisions relating to determination of need in section 1603, except that the Secretary may not approve any plan which imposes as a condition of eligibility—

- (1) an age requirement of more than 65 years,
- (2) a residence requirement which excludes any individual who resides in the State,
- (3) a citizenship requirement which excludes any United States citizen, or any lawfully admitted resident alien who has resided in the United States for at least 5 years,
- (4) a disability or age requirement which excludes any persons age 18 or older who are under a severe disability, as determined under criteria prescribed by the Secretary, or
- (5) a blindness or age requirement which excludes any persons who are blind, as determined under criteria prescribed by the Secretary.

Section 1602(b) provides a special exception for certain States providing aid for the blind without regard to need. As in the existing title XVI, the Federal sharing is limited to expenditures for those in need.

SECTION 1603. DETERMINATION OF NEED

Section 1603(a) provides that each State plan must require the State agency in determining need to take into account any income and resources of an individual claiming aid, along with necessary expenses incurred in earning such income, except that—

- (1) the State agency is not to take into account the home, household goods, or personal effects of the individual, or any other personal or real property which does not exceed \$1,500 in value, or any other property necessary for the family's self-support (subject to any limitation on gross income which may be imposed as provided in section 442(d));
- (2) the State agency is not to consider the financial responsibility of any other individual for the applicant or recipient; except that the State agency may in its discretion, if it is so provided or permitted under State law, consider the financial responsibility of another individual for the applicant or recipient if the applicant or recipient is such individual's spouse, or is

such individual's child who is under the age of 21 or is blind or severely disabled;

(3) if the individual is blind or severely disabled, the State agency will disregard his earned income up to \$85 per month plus one-half of his earned income above that figure, and will disregard additional amounts necessary for achieving self-support pursuant to a State plan for a twelve-month period which may be extended to as long as thirty-six months (except that such additional amounts will be disregarded in the case of an individual who is disabled (but not blind) only if he is undergoing vocational rehabilitation); and

(4) if the individual has attained age 65 and is neither blind nor severely disabled, the State agency may disregard his earned income up to \$60 per month and one-half of his earned income above that figure.

Section 1603(a) also permits the State agency in determining an individual's need (before disregarding any amounts under the preceding paragraphs) to disregard up to \$7.50 of any income, and refers by cross reference to the additional \$4 disregard which is required in the case of OASDI recipients by section 1007 of the Social Security Amendments of 1969 (discussed below under section 203 of the bill).

Section 1603(b) requires a State plan to provide also that—

(1) each eligible individual, other than an individual who is institutionalized, will receive financial assistance equal to at least \$110 per month less any income which is not disregarded under section 1603(a);

(2) the standard of need applied for determining eligibility for and amount of aid will not be lower than (A) the standard applied for this purpose under the State's title XVI plan as in effect on the date of the enactment of the family assistance program, or (B) if the State had no such plan on that date, the standard of need which was in effect and approved on such date under the State's plan under title I, X, or XIV, whichever would apply to the individual (or the highest such standard which was or would have been applicable if the individual falls within two or more categories or does not fall within any of them); and

(3) no payments will be made under the plan to an individual who is considered a member of a family receiving family assistance benefits or supplementary payments under part D or E of title IV or training allowances under part C of such title (but the individual may in any case elect not to be considered a member of such a family).

Section 1603(c) contains a cross-reference to the special provisions applicable to Puerto Rico, the Virgin Islands, and Guam under section 1108(e) (as added by section 403 of the bill).

SECTION 1604. PAYMENTS TO STATES FOR AID TO THE AGED, BLIND, AND DISABLED

Section 1604 directs the Secretary to pay to each State which has a plan approved under the revised title XVI, for each calendar quarter, an amount equal to the sum of the following proportions of the total amounts expended during each month of such quarter as aid to the aged, blind, and disabled under the plan—

(1) 90 percent of such expenditures up to the product of \$65 multiplied by the total number of recipients of such aid for such month; plus

(2) 25 percent of the amount by which such expenditures exceed those which may be counted under paragraph (1), but only up to the product of the maximum permissible level of assistance per person in which the Federal Government will participate financially, as determined by the Secretary, multiplied by the total number of recipients of such aid for such month.

Section 1604 further provides that in the case of Puerto Rico, the Virgin Islands, and Guam the maximum permissible level of assistance under paragraph (2) may be lower than in the case of individuals in the other States.

SECTION 1605. ALTERNATE PROVISION FOR DIRECT FEDERAL PAYMENTS TO INDIVIDUALS

Section 1605 provides that the Secretary may enter into an agreement with any State under which he will make the payments of aid to the aged, blind, and disabled provided for under the State plan directly to individuals in such State, and perform related State functions. The State would reimburse the Secretary for the State's share of such payments.

SECTION 1606. OVERPAYMENTS AND UNDERPAYMENTS

Section 1606 provides for adjustments of overpayments and underpayments where the Secretary makes direct payment to individuals in a State as provided in section 1605. In the case of overpayments, the Secretary is to avoid penalizing people who were without fault if adjustment or recovery would defeat the program's purposes, or be against equity and good conscience, or might, because of the small amounts involved, impede effective administration.

SECTION 1607. OPERATION OF STATE PLANS

Section 1607 provides that if the Secretary finds after reasonable notice and opportunity for hearing that a State is not meeting the Federal requirements, he will withhold further payments under the State plan, or under the part of the plan affected, until the noncompliance is corrected.

SECTION 1608. PAYMENTS TO STATES FOR SERVICES AND ADMINISTRATION

Section 1608(a) provides that a State may qualify for increased Federal payments as provided in section 1608(b) for services made available to applicants for and recipients of aid to the aged, blind, and disabled if the State plan provides at least those services which are prescribed by the Secretary to help them attain or retain capability for self-support or self-care.

Section 1608(b) provides that the Secretary will pay to each State an amount equal to 75 percent of its expenditures for services to help applicants or recipients attain or retain capability for self-support or self-care, other services likely to prevent or reduce dependency, and

services directed toward the training of personnel employed or preparing for employment in the State or local agency administering the plan, plus an amount equal to one-half of its expenditures for other services furnished under the plan.

Section 1608(c) provides that the services are to be furnished by the State or local agency staff except as specified by the Secretary.

Section 1608(d) provides that the rate of the Federal payment with respect to amounts expended for administration are to be determined under methods and procedures permitted by the Secretary.

Section 1608(e) provides that the State may be paid for only one-half its expenditures for services in any quarter if its plan does not include the self-support or self-care services prescribed under or specified in section 1608 (a) and (b).

Section 1608(f) provides that if the Secretary finds after notice and opportunity for hearing that a State's plan providing services prescribed under or specified in section 1608 (a) and (b) is failing to comply with the requirements of such section, or that in the administration of such plan there is a failure to comply substantially with its provisions, he may make the payments for any or all of such services at the 50-percent rate (as in the case of a State to which section 1608(e) applies) instead of at the 75-percent rate otherwise applicable until such failure ceases.

SECTION 1609. COMPUTATION OF PAYMENTS TO STATES

Section 1609(a) authorizes the Secretary to estimate, before each quarter, the amount to which the State is entitled under its plan for aid, services, and administration, and to pay the estimated amounts in installments adjusted for any prior overpayments or underpayments.

Section 1609(b) provides that the pro rata share due the United States for recovery of any aid furnished is to be adjusted as described in section 1609(a).

Section 1609(c) provides that when the Secretary's estimate is made, available appropriations are deemed obligated.

SECTION 1610. DEFINITION

Section 1610 defines "aid to the aged, blind, and disabled" to mean money payments to needy individuals who are age 65 or older or are blind or severely disabled, other than inmates of a nonmedical public institution and patients under age 65 in a mental or tuberculosis institution. The term also means payments to another person on behalf of such a needy individual if the applicable State plan provides (1) for a determination of the individual's inability to manage funds where making direct payment would be contrary to his welfare, (2) for making payments to such other person only if the individual's needs will be met by doing so, (3) that special efforts will be made to improve the individual's capacity to manage funds, (4) for a periodic review of the determination to pay another person and for appointment of a legal guardian, if appropriate, and (5) an opportunity for a fair hearing.

The standards for determining blindness and severe disability are to be established by the Secretary of Health, Education, and Welfare.

SECTION 202. REPEAL OF TITLES I, X, AND XIV OF THE SOCIAL SECURITY ACT

Section 202 of the bill repeals title I of the Social Security Act (grants to States for old-age assistance and medical assistance for the aged), title X of the Act (grants to States for aid to the blind), and title XIV of the Act (grants to States for aid to the permanently and totally disabled). The aid under these three programs will be provided in the bill under one program—title XVI (as amended by section 201 of the bill).

SECTION 203. ADDITIONAL DISREGARDING OF INCOME OF OASDI RECIPIENTS IN DETERMINING NEED FOR AID TO THE AGED, BLIND, AND DISABLED

Section 203 of the bill amends section 1007 of the Social Security Amendments of 1969 to make permanent the provision (now applicable only through June 1970) which requires a State to disregard up to \$4 per month of an individual's benefit under the old-age, survivors, and disability insurance program in determining such individual's need for aid under the State's title XVI program if disregarding such amount is necessary to ensure that his total income under the two programs will reflect the 15-percent increase in benefits made by the 1969 Amendments.

SECTION 204. TRANSITION PROVISION RELATING TO OVERPAYMENTS AND UNDERPAYMENTS

Section 204 of the bill provides for adjustment under title XVI of the Act (as amended by section 201 of the bill) of any overpayment or underpayment which the Secretary determines was made to a State under the existing title I, X, or XIV of the Act (which are repealed by section 202 of the bill), or the existing title XVI of the Act (which is amended by section 201 of the bill).

SECTION 205. TRANSITION PROVISION RELATING TO DEFINITIONS OF BLINDNESS AND DISABILITY

Section 205 of the bill gives the States a grace period during which they can be eligible to participate under title XVI of the Act (as amended by section 201 of the bill) without changing their tests of disability or blindness. The grace period will end for any State with the July 1 which follows the close of the first regular session of its State legislature beginning after the enactment of the bill.

TITLE III—MISCELLANEOUS CONFORMING AMENDMENTS

Title III of the bill amends various provisions of the Social Security Act to reflect the programs established under titles I and II of the bill and to eliminate references to titles I, X, and XIV of the Act (which are repealed by section 202 of the bill).

SECTION 301. AMENDMENT TO SECTION 228(d)

Section 301 of the bill changes references in section 228(d)(1) of the Act, which precludes benefits under section 228 (benefits at age 72 for certain uninsured individuals) for individuals receiving cash benefits under the programs established by the bill.

SECTION 302. AMENDMENTS TO TITLE XI

Section 302 of the bill amends title XI of the Act (general provisions) by repealing section 1118 (alternative Federal payment with respect to public assistance expenditures) and by changing references in several other sections.

SECTION 303. AMENDMENTS TO TITLE XVIII

Section 303 of the bill amends title XVIII of the Act by changing references in section 1843 (State agreements for coverage of eligible individuals who are receiving money payments under public assistance programs (or are eligible for medical assistance)) and section 1863 (consultation with State agencies and other organizations to develop conditions of participation for providers of services).

SECTION 304. AMENDMENTS TO TITLE XIX

Section 304 of the bill changes references in various provisions of title XIX (grants to States for medical assistance programs), and requires the States to provide medical assistance for individuals who are eligible for State supplementary payments under part E of title IV of the Act (as added by section 101 of the bill) or who would be eligible for cash assistance under an existing State plan for aid to families with dependent children if it continued in effect and included dependent children of unemployed fathers.

TITLE IV—GENERAL

SECTION 401. EFFECTIVE DATE

Section 401 of the bill provides that the amendments made by the bill will become effective on July 1, 1971, except that—

(1) in the case of a State which (on that date) is prevented by statute from making supplementary payments under the new part E and the legislature of which does not meet in a regular session closing after the enactment of the bill and on or before that date, none of such amendments will apply until the first July 1 which follows the close of the first regular session of such legislature closing after that date (unless the State theretofore certifies that it is no longer prevented from making the payments, in which case the amendments become effective at the beginning of the first calendar quarter following the certification); and

(2) in the case of a State which (on that date) is prevented by statute from meeting the requirements contained in the revised section 1602 and the legislature of which does not meet in a regular session closing after the enactment of the bill and on or before

that date, the amendments made by title II of the bill will not apply until the first July 1 which follows the close of the first regular session of such legislature closing after that date (unless the State theretofore submits a State plan meeting those requirements, in which case the amendments made by title II become effective on the date of submission of the plan).

The special 1950 rule relating to public assistance for Navajo and Hopi Indians is repealed, effective at the same time as the amendments made by the bill. An exception to the general effective date provision is made in the case of the new authorization (in the revised part C of title IV of the Act) for child care services for persons undergoing training or employment; this authorization is effective upon the enactment of the bill.

SECTION 402. SAVING PROVISION

Section 402(a) of the bill provides that for each quarter beginning after June 30, 1971, and prior to July 1, 1973, the Secretary of Health, Education and Welfare will reimburse any State making supplemental payments under the new part E of title IV and payments of aid to the aged, blind, and disabled under the revised title XVI, to the extent that 70 percent of the payments required under part E plus the State's share of expenditures under the revised title XVI exceeds the State's share of the expenditures which would have been incurred under title I (old-age assistance and medical assistance for the aged), part A of title IV (aid and services to needy families with children), title X (aid to the blind), title XIV (aid to permanently and totally disabled), and the existing title XVI had they continued in effect.

Section 402(b)(1) provides that the non-Federal (or State's) share of expenditures for a quarter subsequent to June 1971 under the revised title XVI of the Act means the difference between (1) of the total payments made under title XVI for such subsequent quarter which would have been included as aid to the aged, blind, or disabled under the plan in effect in June 1971, plus the additional expenditures required under such title as revised by the bill; and (2) the total amounts determined under section 1604 of the Act for such State with respect to the State's expenditures for such subsequent quarter.

Section 402(b)(2) provides that the non-Federal share of expenditures for a quarter subsequent to June 1971 which would have been made had titles I, IV, X, and XVI of the Act continued in effect means the difference between (1) the payments which would have been made under such titles as in effect in June 1971 if the plans under such titles as then in effect had continued in effect during such subsequent quarter and had included payments to dependent children of unemployed fathers, and (2) the amounts which would have been determined under sections 3, 403, 1003, 1403, and 1603, or under section 1118, of the Act with respect to expenditures for such quarter.

SECTION 403. SPECIAL PROVISIONS FOR PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

Section 403 of the bill adds to section 1108 of the Act a new subsection (e) to provide that in Puerto Rico, Guam, and the Virgin Islands—

(1) the eligibility level for and amount of family assistance benefits,

(2) the irregular income excluded,

(3) the resources limitations,

(4) the first cut-off point in the Federal reimbursement formula for payments to the aged, blind, and disabled, and

(5) the income floor for the aged, blind, and disabled

will be reduced in proportion to the extent by which the per capita income of each is below that one of the fifty States which has the lowest per capita income.

The new section 1108(e) also provides that the Secretary will promulgate between July 1 and September 30 of each even-numbered year the amounts to be used for these purposes during the following 2-fiscal-year period in Puerto Rico, Guam, and the Virgin Islands, and that in no case will the amounts determined for one period be lower than the amounts for the preceding period.

SECTION 404. MEANING OF SECRETARY AND FISCAL YEAR

Section 404 defines the term "Secretary" to mean the Secretary of Health, Education, and Welfare (unless the context otherwise requires), and defines the term "fiscal year" to mean a period beginning any July 1 and ending with the close of the following June 30.

VI. ADDITIONAL VIEWS OF CONGRESSMAN SAM M. GIBBONS ON H.R. 16311

I voted for the family assistance program in the Ways and Means Committee, and I plan to vote for it on final passage.

But unless we consider the existing food stamp program we are going to create a scrambled welfare mess.

Congress created the food stamp program in 1964 for the purpose of providing food for the needy.

It has failed to accomplish this basic goal—and at a great administrative expense. Only 40 percent of those who are eligible have ever been able to participate in it because of its high administrative expenses and because it has not been made available on a nationwide basis. The Federal administrative expenses of this program for fiscal 1969 were about 10 percent of the food stamp benefit. The local administrative expenses have been running about 5 percent of the food stamp benefit and the poor have ended up with something that many regard as “funny” money.

This indicates to me that there are serious flaws in the program, which in my opinion are incurable under any stamp system.

For these and other reasons, I have concluded that we should convert from food stamps to cash payments of the same bonus amount above and beyond the benefit paid under the family assistance program.

Under present law, the food stamp applicant must put up a relatively small sum of his own cash (from whatever source) and receive in return a larger amount in food stamps. The difference between what he pays in cash and what he can buy with the stamps is the free food stamp bonus.

I propose that the bonus now given in extra food stamps be given an equivalent amount of cash. Whether the recipient receives cash or food stamps his purchasing power will not be affected, but Federal and local governments will save administrative costs if the benefits are distributed in cash rather than in stamps.

Why have I come to the conclusion that we should abandon the food stamp program for cash payments?

There are several reasons, but basically two.

The first is that under the present food stamp bonus plan, there is excessively expensive and duplicative administration. These costs could be reduced to a minimum under a cash plan.

The second reason is that the present plan imposes such degrading and discouraging experiences that less than half of those who need and are entitled to food stamps get any help under the food stamp plan.

A third reason is that almost all the knowledgeable experts on this matter, including the President and his Secretaries of Health, Education, and Welfare, and Agriculture, agree that a cash bonus is better than stamps. Yet they have failed to put forward a solution. My opinion is that we should solve this problem now. Congress should not avoid this responsibility because others fail to lead.

I will expand on my reasons for proposing a change later in these remarks, but first I want to explain in detail how the cash plan I urge would work.

There are 20 million individuals eligible under the family assistance plan and about 3 million adults now receiving categorical assistance (blind, disabled, etc.). They would, under my proposal, be entitled to the cash equivalent of the bonus stamps which they would have received according to the food stamps issuing schedule now in effect.

In sum, the added cash payment to each family above and beyond the FAP payments would be the same as the food stamp bonus they would have received if enrolled in the food stamp program.

To illustrate, let us use a family of four, with no income except the minimum of \$1,600 under the family assistance plan. Its monthly net income would be \$133.33. For a payment of \$34 in cash, this family would receive \$106 in food stamps. The \$72 difference between the cash paid and stamps received would equal its monthly food stamp bonus.

Under my proposal, this same \$72 would be paid the family as a cash bonus, on top of its \$133.33 in monthly FAP payment, thus yielding the family a cash total of \$205.33 a month.

Under existing law, the family in the food stamp program would have to pay \$34 of its \$133.33 FAP cash assistance to get the extra stamps, leaving it \$99.33 in cash and \$106 in food stamps. However, monthly purchasing power would be the same, \$205.33 in either case.

The proposal that I advocate is not new. In the President's budget for this year (1971) on page 176 the following illustration is made, and the only difference between that illustration and with the one I have just given you is that it is given in annual terms, whereas, I have given you the figures on a monthly basis. The President's proposal on page 176 is stated as follows:

Taken together, FAP and the improved food stamp program would provide significantly improved benefit levels for many poor families. A family of four with no other income would receive a total of \$2,464 annually—\$1,600 in cash from FAP, and \$864 in the form of the food stamp bonus (\$1,272 in stamps less a purchase price of \$408).

The following table sets this out schematically for a family of four at the \$1,600 level:

BENEFITS

	Month	Year
(a) Separate programs:		
Cash.....	\$133.33	\$1,600
Less cash spent for food stamps.....	34.00	408
Total cash.....	99.33	1,192
Value of food stamps.....	106.00	1,272
Total purchasing power.....	205.33	2,464
(b) Merged programs:		
Cash.....	133.33	1,600
Cash value of food stamps.....	72.00	864
Total purchasing power.....	205.33	2,464

Note: There is no change in family purchasing power except under the separate program the family ends up with 48 percent cash and 52 percent in food stamps; whereas, under the merged programs the family ends up with the entire purchasing power in cash.

For a family of four at the \$3,000 level from any combination of FAP payments, state supplementation, and earnings, the following would occur:

BENEFITS

	Month	Year
(a) Separate programs:		
Cash.....	\$250	\$3,000
Less cash spent for food stamps.....	72	864
Total cash.....	178	2,136
Value of food stamps.....	106	1,272
Total purchasing power.....	284	3,408
(b) Merged programs:		
Cash.....	250	3,000
Cash value of food stamps.....	34	408
Total purchasing power.....	284	3,408

Note: There is no change in family purchasing power except under the separate program the family ends up with 63 percent cash and 37 percent in food stamps; whereas, under the merged programs the family ends up with the entire purchasing power in cash.

For an aged adult receiving \$110 a month and nothing more, the following would obtain:

BENEFITS

	Month	Year
(a) Separate programs:		
Cash.....	\$110	\$1,320
Less cash spent for food stamps.....	-18	-216
Total cash.....	92	1,104
Value of food stamps.....	+28	336
Total purchasing power.....	120	1,440
(b) Merged programs:		
Cash.....	110	1,320
Cash value of food stamps.....	+10	+120
Total purchasing power.....	120	1,440

Note: There is no change in the adult purchasing power except under the separate program he ends up with 77 percent cash and 23 percent in food stamps; whereas, under the merged programs the adult ends up with the entire purchasing power in cash.

The above arithmetic, particularly for the \$1,600 family, dramatically demonstrates part of my case for changing from bonus food stamps to bonus cash benefits.

What family in America, poor or otherwise, wants to be compelled to receive over half its total purchasing power in the form of script which can only be used for one of its needs—food—and this on penalty of receiving no family food assistance at all unless it submits to this compulsory budgeting?

What family wants even more than one-third of its purchasing power tied up in food, untouchable in emergency? The average American family spends only 16.5 percent of its disposable income on food. Granted the average family's income is higher than that of a typical poor family, but must the poor be locked into a forcible formula which makes them spend three times the average for food alone? I think not, and I want to detail some of my reasons as to why not.

As I have already noted, most of the experts, including the President, think cash payments are superior to stamp bonuses.

Let me quote administration sources first:

In his Welfare message to Congress on August 11, 1969, President Nixon himself said, in part:

"For dependent families there will be an orderly substitution of food stamps by the new direct monetary payments" (p. 106 of hearings before the Committee on Ways and Means, House of Representatives, pt. 1 of 7).

In this same speech, the President said:

This Administration, after a careful analysis of all the alternatives is committed to a new departure that will find a solution for the welfare problem. The time for denouncing the old is over; the time for devising the new is now (p. 104).

But apparently not right now!

The President went on to say that the "new system will lessen welfare redtape and provide administrative cost savings * * *" (p. 108). But this will not be true if the present food stamp program, which entails huge and disproportionate administrative costs is retained. (I detail these costs later in this statement.)

Again, earlier on May 6, 1969, the President gave it as his view that "the food stamp and direct (commodity) distribution programs * * * both programs are clearly in need of revision."

He then went on to urge a \$1 billion increase in spending for the food stamp and other food programs.

On September 15, 1969, before the Senate Select Committee on Nutrition and Human Needs, Secretary of Agriculture Hardin spoke in a similar vein.

He said, in part " * * * When the President delivered his message of May 6 (1969), he made it clear that it was time to go ahead and reshape the food stamp program and make it workable, available and attractive * * *"

My only difference with the President and Secretary Hardin is how and when we should start making the food stamp program all of those things.

My view is that the food can only be made fully available and the dispensing of it workable by substituting a cash bonus plan for stamps now.

Why wait? Why not realize these savings, administrative and otherwise, by converting food stamps into cash, with the payments administered by the same agency which will administer family assistance?

HEW Secretary Finch told this same Senate Committee on the same day that—"For several reasons, our ultimate goal over the years should be to move toward a wholly cash income support system and away from in-kind multiple programs * * *. This Administration believes that over the years cash assistance would eventually be substituted for food stamp programs in a way which leaves the individual at least as well off in total benefits * * *." Why not now?

Secretary Finch further said that the "welfare and food stamp systems need to be viewed together as part of a single package and the Congress should consider reforms of those systems at the same time with an eye to their relationship to each other." Why not now?

Secretary Finch is also on the record as saying that "cash assistance provides the maximum flexibility and personal responsibility for the individual. Cash enables the recipient to substitute his own judgment of how best to meet his needs for the determination of a faraway government. The individual determines how he allocates his income and how much to spend on food."

Other knowledgeable experts, not so intimately associated with the Nixon administration, have endorsed a cash plan such as I proposed, and suggested it be immediately.

Dr. Harold Watts of the University of Wisconsin, who testified before the Ways and Means Committee, says that "food stamps are a bad bargain in comparison to general cash benefits."

The President's Commission on Income Maintenance Programs made a similar recommendation.

The latter group also notes the difficulty of policing an augmented food stamp program. Since many families will have more stamps than cash in hand, there will be a strong inducement to either buy ineligible items with stamps or else sell the stamps or food obtained with them for cash. Either way, there will be strong pressure to violate the law.

I have not dwelt on the personally degrading and harassing experiences which food stamp recipients must undergo to get their stamps such as waiting hours in long lines, going to outdoor windows of banks which issue the stamps, even in snow or rain, and how they become conspicuous at grocery counters where they must separate stamp eligible items in one stack and other purchases in another stack. I might add that such embarrassments and harassments, which this program inflicts on those who must use it or go hungry, is doing nothing to solve the already acute and explosive problems in our slum ghettos where many of the food recipients live. It aggravates such problems.

But leaving aside the indignity and inconvenience of the stamp program, there is an overwhelmingly strong argument against it:

This is the expensive and duplicative administrative cost and procedures which could be reduced to a minimum under a combined food and FAP cash program.

Administrative costs of the present food stamp program are considerable. To disperse \$228.8 million in stamp bonuses in fiscal 1969, the Government had to spend \$22.2 million or 10 percent of the added bonuses in administrative costs. In fiscal 1971, with a projected \$1.2 billion food stamp program, projected administrative costs are estimated at \$50 million. That estimate is probably low. But even if correct, when the planned \$2.5 billion food stamp program takes effect early in fiscal 1972, Federal administrative costs will run to a minimum of \$100 million and perhaps as high as \$250 million, given last year's operating experience.

There will be other administrative expenses as well. The Federal Government pays 62.5 percent of State costs for certifying nonpublic assistance households as eligible for food stamps. This will soar further when all individuals eligible for the existing program take advantage of it. With a cash plan in operation, there would be no necessity for this second certification.

Local costs of this program, which are not reimbursed by the Federal Government are also substantial. Some banks, for example, charge

as much as 90 cents every time they sell a book of stamps to an eligible recipient. Should stamps be issued more than once a month in the future, this cost would go up still more. State and local government costs for issuance could run to \$125 million, not counting the certification costs.

Under a cash plan, double certification, double staffs, double investigations and all the other duplicative administrative procedures could be eliminated.

With food stamps and family assistance programs merged into a single cash payment, there would be no added administrative cost for calculating the food stamp bonus and adding the cash equivalent to the FAP cash payment.

Indeed, overall, there would be less administrative cost. We could save most of the \$150 million it will cost the Federal Government to administer the food stamp program by fiscal 1972, and the possible \$175 million it will cost local and State governments for the same program.

To sum up, there is a simple and rational substitute for the "funny money," which we call food stamps and which now cost \$2.20 for every \$2 in stamps issued. It is to convert to cash payments and to abolish food stamps and to do it now. By so doing, we will simplify administration and liquidate excessive expenses which are inherent in any stamp plan.

VII. DISSENTING VIEWS OF HON. AL ULLMAN, HON. PHIL LANDRUM, AND HON. OMAR BURLESON ON H.R. 16311

We concur that the Federal welfare system should be renovated, and agree with portions of the bill that help attain that objective.

We do not concur, however, with provisions of the bill under which another 15 million Americans, the working poor, would be added to the welfare rolls. The aim of assisting low-income wage earners is frustrated by the very provisions of the bill.

The argument that the bill requires welfare recipients for the first time to register with public employment service agencies begs the issue. Neither the funding nor the administrative provisions of the bill are sufficient to cope with the massive increase in paperwork and job placement problems that would follow the addition of nearly 3 million new names to the work registration rolls. The increase in job-training slots and funding planned under the bill would, in our judgment, fall far short of meeting the needs of the present number of welfare recipients, much less those of millions more.

Virtually no improvement is offered for the administrative tangle that makes the existing welfare program so ineffective. The bill merely places a new Federal layer on top of a system that is already a bureaucratic quagmire.

For all the rhetoric about work incentives, the bill clearly puts cash payments first. It ultimately establishes the basis for a guaranteed annual income through a negative tax formula. We do not concur that the cash incentive approach to welfare is either proven or sound, or that it would ever attain its purported objective of reducing the welfare rolls. Research in this whole area is fragmentary and entirely inconclusive.

We fully concur that the Federal payments in the adult category—to the aged, the blind, and the disabled—be significantly increased as provided by the bill. We believe that the inflationary pressures of the economy today make it impossible for individuals in these welfare categories to exist on their present fixed incomes.

But we do not concur with the thrust of the bill in its family assistance provisions. It would permanently consign more than 10 percent of our population to welfare handouts. The bill would institutionalize poverty, not eliminate it.

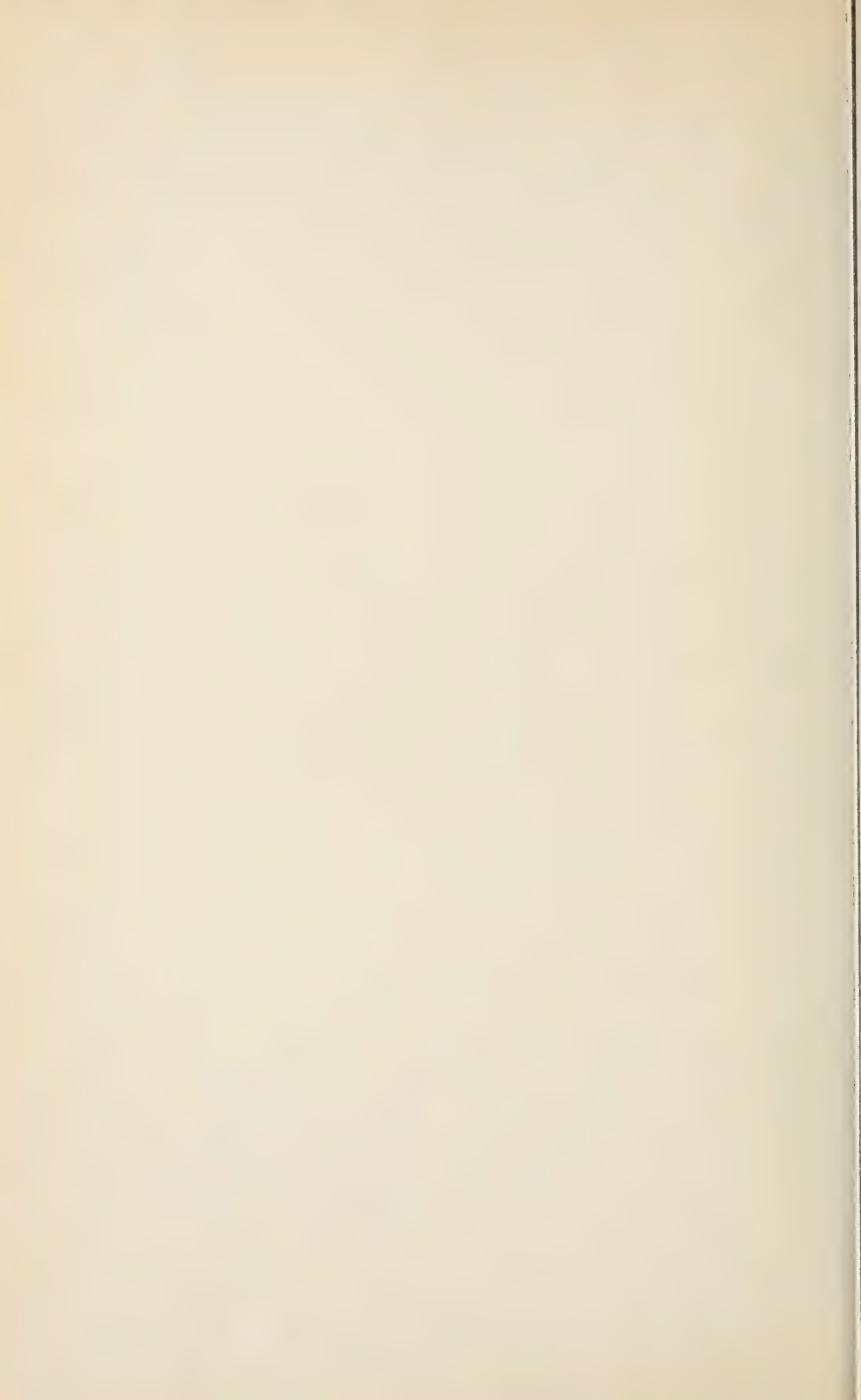
We believe the need is for tighter Federal standards applied to the present system and aimed at more efficient and effective administration. Above all, the need is for greatly expanded funding of existing programs—the work incentive (WIN) program, special projects, JOBS and child care. We believe that these programs, properly funded well beyond the bill's limited provisions, can produce positive results.

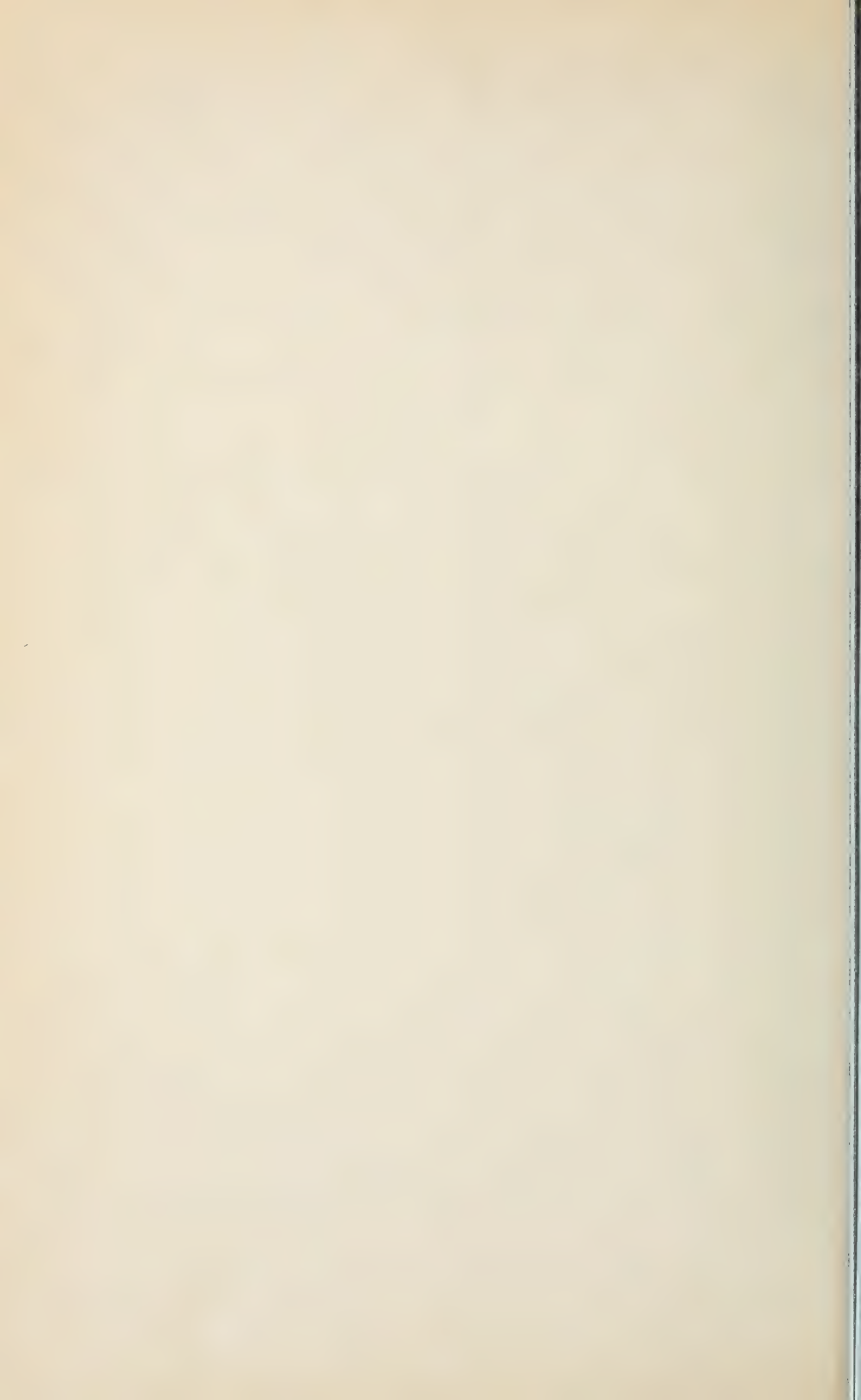
In our judgement, the first step in welfare reform should be to make our present system effective for the 10 million Americans already on the welfare rolls, and offer them a real opportunity to lift

themselves out of poverty. Only after we have successfully achieved a sound structure should we consider bringing millions more into the system.

AL ULLMAN.
PHIL M. LANDRUM.
OMAR BURLESON.







Report of the Committee on
Ways and Means on H. R. 17550,
Social Security Amendments of
1970, House Report No. 91-1096



SOCIAL SECURITY AMENDMENTS
OF 1970

REPORT
OF THE
COMMITTEE ON WAYS AND MEANS

ON

H.R. 17550

TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE INCREASES IN BENEFITS, TO IMPROVE COMPUTATION METHODS, AND TO RAISE THE EARNINGS BASE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAM WITH EMPHASIS UPON IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF SUCH PROGRAMS, AND FOR OTHER PURPOSES



MAY 14, 1970.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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SOCIAL SECURITY AMENDMENTS OF 1970

MAY 14, 1970.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLS, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 17550]

The Committee on Ways and Means, to whom was referred the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. PRINCIPAL PURPOSES OF THE BILL

The general subject of social security has been the principal order of business before the Committee on Ways and Means for the past several months. On October 15, 1969, your committee commenced holding extensive public hearings on all aspects of the Social Security Act, including the old-age, survivors, and disability insurance program, the public assistance programs, and the medicare and medicaid programs.

The bill now being reported is the third separate bill relating to these programs recommended for action by your committee as a part of its recent deliberations. Last December, your committee recommended, and Congress enacted, an urgently needed 15-percent general increase in social security benefits, effective beginning January 1, 1970. In March of this year, your committee reported H.R. 16311, the proposed Family Assistance Act of 1970, which passed the House on April 16, and which related to the public assistance programs established under the Social Security Act.

The bill now being recommended by your committee contains amendments to the old-age, survivors, and disability insurance (OASDI) program, including a 5-percent benefit increase first applicable to benefits for the month of January 1971, and amendments to the medicare and medicaid and child health programs.

The provisions of the bill relating to the OASDI program are those which your committee believes are most urgently needed at the present time and which can be financed from the funds available under the financing provisions of the law as modified by the bill. In addition to an increase in social security benefits, the bill includes improvements in the provisions of the law relating to the social security retirement test; benefits for widows, widowers, and other dependents; the method of computing benefits; benefits for certain persons based on disability; and minor extensions of coverage.

The provisions of the bill relating to medicare, medicaid, and maternal and child health are designed primarily to improve the effectiveness of these programs.

Your committee conducted a thorough review of the operations of the two major health programs in the Social Security Act—medicare and medicaid. These programs taken together accounted for \$9 billion of the total of \$60 billion which was expended for health care in the United States in fiscal year 1969. Clearly, the impact which these programs have on the health industry is quite substantial. Clearly, too, developments in the health care field have a substantial impact on these programs.

Your committee became convinced, after hearing from many witnesses in both public and executive sessions, that there are many serious deficiencies in the operation and administration of the present programs which need correction. Some of these deficiencies can be attributed to inadequate planning and uneven performance by the Federal Government and its agents, and the States, particularly in the early stages of these programs. Your committee has received assurances from the Department of Health, Education, and Welfare that the strong efforts now being carried on to improve the operating effectiveness of these programs will continue.

Your committee also concluded that there is no simple or single solution to the problems now existing in the health care field which adversely affect these programs. But your committee does believe that there are many relatively small modifications which can and should be made in these programs—changes which, while perhaps not very significant taken singly, as a whole show great promise for making significant advances in accomplishing the goal of making these programs more economical and more capable of carrying out their original purposes.

The provisions in the bill dealing with the operating effectiveness of the programs should be viewed as a related set of provisions designed to accomplish that objective.

The cost of the changes relating to the OASDI program and of meeting the existing actuarial deficit in the hospital insurance program would be met by increasing the earnings base from \$7,800 to \$9,000 and by revising the contribution rate schedules.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. AMENDMENTS RELATED TO THE SOCIAL SECURITY CASH BENEFITS PROGRAM

Cash benefit increase

Social security payments to the 26.2 million beneficiaries on the rolls at the end of January, 1971, and to those who come on the rolls after that date would be increased by 5 percent. The benefit increase would be effective for the month of January 1971 (payable in February) and would mean additional benefit payments of \$1.7 billion in the first 12 months.

Effective date—January 1, 1971.

Liberalization of the retirement test

The amount a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year would be increased from the present level of \$1,680 to \$2,000. Then, similar to present law, for the next \$1,200 of earnings (from \$2,000 to \$3,200 a year under the new provision) there would be a reduction of \$1 in a recipient's social security benefits for each \$2 of earnings. A reduction of \$1 would be made for each \$1 of annual earnings above \$3,200. In the year in which a person attains age 72 his earnings in and after the month in which he attains age 72 would not be included in determining if his earnings in that year exceed \$2,000. In 1971 about 900,000 beneficiaries would receive additional benefits and about 100,000 persons who would receive no benefits under present law would receive some benefits. Additional benefit payments for the first year would be about \$475 million.

Effective date—Taxable years ending after 1970.

100 percent widow's and widower's benefit at age 65 and reduced benefits for widowers at age 60

Under present law, a widow's (or dependent widower's) benefit applied for at age 62 or later is equal to 82½ percent of the primary insurance amount of the wage earner. An actuarially reduced benefit may be received by a widow at age 60. Under the bill a widow or widower would be entitled to a benefit equal to 100 percent of the primary insurance amount, if first applied for at age 65 or later. Benefits applied for between age 62 and 65 would be proportionately increased over the present 82½ percent rate according to the age of the applicant at the time of application. In addition, widowers under age 62 would be granted the same privilege of applying for benefits on an actuarially reduced basis as now applies to widows.

About 3.3 million widows and widowers on the rolls at the end of January 1971 would receive additional benefits, and \$700 million in additional benefit payments would be made in the first 12 months.

Effective date—January 1, 1971.

Age-62 computation point for men

Under present law, the method of computing benefits for men and women differs in that years up to age 65 must be taken into account in determining average earnings for men, while for women, only years up to age 62 must be taken into account. Also, benefit eligibility is figured up to age 65 for men and up to age 62 for women. These differences which favor women over men, would be eliminated by applying the same rules to men as now apply to women.

In the first 12 months, an additional \$925 million in benefits would be paid out; an estimated 10.2 million people on the rolls on the effective date would receive larger benefits under this provision; in addition 60,000 persons—workers and their dependents not eligible under present law—would be added to the rolls under the change in benefit eligibility requirements for men.

Effective date—January 1, 1971.

Eliminate reduction in benefits in certain cases

Under present law, when a person receives a benefit in one benefit category that is reduced because it is taken before age 65, and also receives another benefit in a different benefit category beginning with the same month or a later month, the second benefit is generally reduced to reflect the reduction in the first benefit. For example, when a woman applies for a retirement benefit prior to age 65, it is computed under the actuarial reduction formula; if she applies for a spouse's benefit at age 65 or later, it is reduced to take account of the fact that she took her retirement benefit early. The bill would eliminate the actuarial reduction of the spouse's benefit in such cases. The same rule would apply to dependent husbands entitled to spouses' benefits.

Approximately 100,000 beneficiaries would be immediately affected by this provision, which would result in additional benefit payments estimated at \$10 million during the first 12 months.

Effective date.—Six months after the month of enactment.

Elimination of the support requirements for divorced women

Under present law, benefits are payable to a divorced wife age 62 or older and a divorced widow age 60 or older if her marriage lasted 20 years before the divorce, and to a surviving divorced mother. In order to qualify for any of these benefits a divorced woman is required to show that: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from her former husband pursuant to a written agreement, or (3) there was a court order in effect providing for substantial contributions to her support by her former husband. Your committee's bill would eliminate these support requirements for divorced wives, divorced widows, and surviving divorced mothers.

Effective date.—January 1, 1971.

Disability insured status for individuals who are blind

Under present law, to be insured for disability insurance benefits a worker must be fully insured and meet a test of substantial recent covered work (generally 20 quarters of coverage in the period of 40 calendar quarters preceding disablement). The bill would eliminate the test of recent attachment to covered work for blind people; thus a blind person would be insured for disability benefits if he is fully insured—that is, he has as many quarters of coverage as the number of calendar years that elapsed after 1950 (or the year he reached age 21, if later) and up to the year in which he became disabled.

Effective date.—January 1, 1971.

Disability benefits affected by the receipt of workmen's compensation

Under present law, social security disability benefits must be reduced when workmen's compensation is also payable and the combined payments exceed 80 percent of average current earnings before disablement. Under the bill, social security disability benefits would be

reduced by the amount by which the combined payments under both programs exceed 100 percent of average current earnings before disability.

Effective date.—January 1, 1971.

Wage credits for members of the uniformed services

Present law provides for a social security wage credit of up to \$100 a month, in addition to credit for basic pay, for military service performed after 1967. Under the bill, the additional wage credits would also be provided for service during the period from 1957 (when military service was covered under social security) through 1967. Approximately 130,000 beneficiaries would be affected immediately; \$35 million in additional benefits would be paid out in the first 12 months.

Effective date.—January 1, 1971.

Childhood disability benefits for those disabled before age 22

Under present law, a person who becomes disabled before age 18 may qualify for childhood disability benefits which are payable to a qualified disabled adult son or daughter of an insured retired, deceased, or disabled worker. The bill would provide such childhood disability benefits when disability begins before age 22.

Effective date.—January 1, 1971.

Other OASDI amendments

Your committee also adopted other amendments relating to social security coverage of policemen and firemen in Idaho, the coverage of Federal Home Loan Bank employees, the coverage of certain public hospital employees in New Mexico, the payment of disability insurance benefits on the basis of applications filed after the death of the disabled person, the treatment of earnings of self-employed persons paying taxes on a fiscal year basis, a penalty for furnishing false information to obtain a social security account number, and the amount of a family's benefits when the worker's benefit is increased.

1ST-YEAR BENEFIT COSTS AND NUMBER OF PERSONS AFFECTED BY OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROVISIONS OF H.R. 17550

Provision	Additional benefit payments in 1st 12 months (in millions)	Present-law beneficiaries immediately affected ¹ (in thousands)	Newly eligible persons ² (in thousands)
5-percent benefit increase.....	\$1,700	26,200	36
Modified retirement test ⁴	475	900	100
Age 62 computation point.....	925	10,200	60
100 percent of PIA for widows and widowers.....	700	3,300	.....
Noncontributory credits for military service after 1956.....	35	130	.....
Election to receive larger future benefits by certain beneficiaries eligible for more than 1 actuarially reduced benefit.....	10	100	.....
Children disabled at ages 18 to 21.....	10	.....	13
Liberalized disability insured status requirement for the blind.....	25	.....	30
Liberalized workmen's compensation offset.....	7	55	5
Eliminate support requirement for divorced wives and surviving divorced wives.....	15	.....	10
Actuarially reduced benefits to widowers at age 60.....	(³)	.....	(³)

¹ Present-law beneficiaries whose benefit for the effective month would be increased under the provision.

² Persons who cannot receive a benefit under present law for the effective month, but who would receive a benefit for such month under the provision.

³ Noninsured persons aged 72 and over.

⁴ Additional benefit payments represent benefits for months in calendar year 1971. Some 900,000 persons who will receive some benefits for months in 1971 under present law would receive additional benefits under the provision; about 100,000 persons who will receive no benefits for months in 1971 under present law would receive some benefits under the provision.

⁵ Less than \$500,000 in additional payments; less than 500 newly eligible widowers.

Note: The above figures are not additive because the time periods are not uniform and because a person may be affected by more than 1 provision.

B. AMENDMENTS RELATED TO THE MEDICARE, MEDICAID, AND MATERNAL
AND CHILD HEALTH PROGRAMS

Coverage and benefit changes under medicare

Relationship between medicare and Federal employees benefits.—Your committee bill would require that effective with January 1, 1972, no payment would be made under medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime the Secretary of Health, Education, and Welfare certifies that the Federal employees health benefits program has been modified to make available coverage supplementary to medicare benefits and that Federal employees and retirees age 65 and over will continue to have the benefit of a Government contribution toward their health insurance premiums.

Effective date.—January 1, 1972.

Hospital insurance for the uninsured.—People reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare. Enrollment for supplementary medical insurance is also required. Those who enroll would pay the full cost of the protection—\$27 a month at the beginning of the program, rising as hospital costs rise. States and other organizations, through agreements with the Secretary would be permitted to purchase such protection on a group basis for their retired (or active) employees age 65 or over.

Effective date.—January 1, 1971.

Health maintenance organization option.—Individuals eligible for both part A and part B medicare coverage would be able to choose to have their care provided by a health maintenance organization (a pre-paid group health or other capitation plan). The Government would pay for such coverage on a capitation basis not to exceed 95 percent of the cost of medicare benefits had the beneficiaries not been enrolled with the health maintenance organization.

Effective date.—January 1, 1971.

Improvements in the operating effectiveness of the medicare, medicaid, and maternal and child health programs

Limitation on Federal payment for disapproved expenditures.—Reimbursement amounts to providers of health services under the medicaid, medicare, and maternal and child health programs for capital costs, such as depreciation and interest, would not be made with respect to capital expenditures which are inconsistent with State or local health facility plans.

Effective date.—July 1, 1971 (or earlier if requested by a State).

Experiments and projects in prospective reimbursement and incentives for economy.—The Secretary of Health, Education, and Welfare would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under the medicare, medicaid and maternal and child health programs. In addition, the Secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy, and with community-wide utilization review mechanisms.

Effective date.—Enactment date.

Limits on costs recognized as reasonable.—The Secretary of Health, Education, and Welfare would be given authority to establish and promulgate limits on provider costs to be recognized as reasonable under medicare based on comparisons of the cost of covered services by various classes of providers in the same geographical area. Hospitals and extended care facilities could charge beneficiaries for the costs of services in excess of those that are necessary to the efficient delivery of needed health services (except in the case of an admission by a physician who has a financial interest in the facility).

Effective date.—Enactment date.

Limitation on recognition of physicians fee increases.—Charges determined to be reasonable under the present criteria in the medicare, medicaid, and maternal and child health law would be limited by providing: (a) that for fiscal year 1971 and thereafter medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the previous elapsed calendar year; (b) that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment and services are widely available in a locality.

Effective date.—Fiscal year 1971.

Payments for services of teaching physicians.—Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless other patients who have insurance or are able to pay are also charged for such services and the medicare deductibles and coinsurance amounts are regularly collected. Medicare payment would also be authorized for services provided to hospitals by staff of certain medical schools.

Effective date.—Enactment date.

Termination of payments to suppliers of services who abuse the medicare program.—The Secretary of Health, Education, and Welfare would be given authority to terminate payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. Program review teams would be established to furnish the Secretary professional advice in carrying out this authority.

Effective date.—Enactment date.

Government payment no higher than charges.—Payments for institutional services under the medicare, medicaid, and maternal and child health programs could not be higher than the charges regularly made for those services.

Effective date.—July 1, 1970.

Institutional planning and budgeting.—Health institutions under the medicare program would be required to have a written plan reflecting an operating budget and a capital expenditures budget.

Effective date.—Fifth month following month of enactment.

Guarantee of payment for extended care services.—The Secretary of Health, Education, and Welfare would be authorized to establish specific periods of time (by medical condition) after hospitalization during which a patient would be presumed, for payment purposes, to

require extended care level of services in an extended care facility. A similar provision would apply to posthospital home health services.

Effective date.—January 1, 1971.

Prohibition of reassignments.—Medicare (part B) and medicaid payments to anyone other than a patient, his physician, or other person providing the service, would be prohibited, unless the physician (or, in the case of medicaid, another type of practitioner) is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

Effective date.—Enactment date for medicare; July 1, 1971 (or earlier at the option of the State) for medicaid.

Stopping payment where hospital admission not necessary under medicare.—If the utilization review committee of a hospital or extended care facility, in its sample review of admissions, finds a case where institutionalization is no longer necessary, payment would be cut off after 3 days. This provision parallels the provision in present law under which long-stay cases are cut off after 3 days when the utilization review committee determines that institutionalization is no longer required.

Effective date.—Second month following the month of enactment.

Physical therapy services under medicare.—Under medicare's supplementary medical insurance program, up to \$100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's plan would be included in covered charges. Hospitals and extended care facilities could continue to provide covered physical therapy services to inpatients who have exhausted their days of hospital insurance coverage. Where physical therapy is furnished by a provider of services, or by others under arrangements with the provider, medicare reimbursement to the provider will in all cases be based on a reasonable salary payment for the services.

Effective date.—January 1, 1971.

Changes in Federal matching percentages with respect to certain services.—The Federal medicaid matching for certain outpatient services would be increased and the Federal matching with respect to long-term institutional care would be decreased and certain other limitations would be imposed. Specifically, (1) the Federal matching percentage for outpatient hospital services, clinic services and home health services would be increased by 25 percent; (2) the Federal percentage after the first 60 days of care in a general or TB hospital would be reduced by one-third; (3) the Federal percentage after the first 90 days of care in a year in a skilled nursing home would be reduced by one-third; (4) the Federal matching for care in a mental hospital after 90 days of care would be reduced by one-third and no Federal matching would be available after an additional 275 days of such care during an individual's lifetime; and (5) the Secretary would be authorized to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

Effective date.—January 1, 1971.

Repeal of medicaid provision requiring expanded programs.—The requirement in present law that States have comprehensive medicaid programs by 1977 would be repealed.

Effective date.—Enactment date.

State determination of reasonable hospital costs.—States would be permitted to pay hospitals on the basis of their own determination of reasonable cost, provided there is assurance that the medicaid program would pay the actual cost of hospitalization of medicaid recipients.

Effective date.—July 1, 1971 (or earlier at the option of the State).

Federal matching for modern claims processing systems.—Federal matching at the 90-percent rate would be available under medicaid for the States to set up mechanized claims processing and informational retrieval systems. Federal matching for the continuing operation of such systems would be at the 75-percent rate.

Effective date.—July 1, 1970.

Utilization review in medicaid.—Hospitals and skilled nursing homes participating in the medicaid and maternal and child health programs would be required to have the same type of utilization review committee with the same functions as are required in the medicare program. (Any such committee actually performing such functions for medicare purposes would apply these to medicaid cases.)

Effective date.—July 1, 1971.

Medicaid deductibles for the medically indigent.—States would be permitted to impose cost sharing provisions with respect to people eligible under medicaid programs but not eligible for cash public assistance payments. (Present law requires such cost sharing provisions to vary directly with the amount of the recipient's income.)

Effective date.—January 1, 1971 (or earlier at the option at the State).

Role of State health agencies in medicaid.—State health agencies would be required to perform certain functions under the medicaid and maternal and child health programs relating to the quality of the health care furnished to recipients.

Effective date.—July 1, 1971.

Miscellaneous and technical provisions

Retroactive coverage under medicaid.—States would be required to cover under medicaid the cost of health care provided to an eligible individual during the 3-month period before the month in which he applied for medicaid.

Effective date.—July 1, 1971.

Certification of hospitalization for dental care.—A dentist would be authorized to certify to the necessity for hospitalization to protect the health of a medicare patient who is hospitalized for noncovered dental procedures.

Effective date.—Second month after month of enactment.

Christian Science sanatoriums under medicaid.—Christian Science sanatoriums would be exempted from the medicaid requirement that they have a licensed nursing home administrator and from other inappropriate skilled nursing home requirements.

Effective date.—Enactment date.

Grace period for paying medicare premium.—Where there is good cause for a medicare beneficiary's failure to pay supplementary medical insurance premiums, an extended grace period of 90 days would be provided.

Effective date.—Enactment date.

Extension of time for filing medicare claims.—The time limit for filing supplementary medical insurance claims would be extended where the medicare beneficiary's delay is due to administrative error.

Effective date.—Enactment date.

Enrollment under medicare.—Eligible individuals would be permitted to enroll under medicare's supplementary medical insurance program during any prescribed enrollment period. Beneficiaries would no longer be required to enroll within 3 years following first eligibility or a previous withdrawal from the program. Relief would be provided where administrative error has prejudiced an individual's right to enroll in medicare's supplementary medical insurance program.

Effective date.—Enactment date.

Waiver of medicare overpayment.—Where incorrect medicare payments were made to a deceased beneficiary, the liability of survivors for repayment could be waived if the survivors were without fault in incurring the overpayment.

Effective date.—Enactment date.

Medicare fair hearings.—Fair hearings, held by medicare carriers in response to disagreements over amounts paid under supplementary medical insurance, would be conducted only where the amount in controversy is \$100 or more.

Effective date.—Enactment date.

Collection of medicare premium by the railroad retirement board.—Where a person is entitled to both railroad retirement and social security monthly benefits, his premium payment for supplementary medical insurance benefits would be deducted from his Railroad Retirement benefit in all cases.

Effective date.—Fifth month after month of enactment.

Medicare benefits for people living near U.S. border.—Medicare beneficiaries living in the United States close to the U.S. border would get covered care if the hospital they use is in Canada or Mexico and is closer to their residence than a comparable hospital in the U.S.

Effective date.—Admissions to a hospital after December 31, 1970.

Chiropractors' services.—The Secretary of Health, Education, and Welfare would conduct a study on the desirability of covering chiropractors' services (on a very limited basis) under medicare, utilizing the experiments and experience under the medicaid program. A report on the study, including the experience of other programs paying for chiropractors' services, would be submitted to the Congress within 2 years after enactment of the bill.

C. FINANCING

In order to pay the additional cost of the new OASDI benefits provided and to meet the existing actuarial deficit in the hospital insurance (part A of medicare) program, the tax and benefit base would be increased from \$7,800 a year to \$9,000 a year, starting January 1, 1971, and a new schedule of tax rates would be provided as follows:

[Percent]

Period	OASDI		HI		Total	
	Present law	H.R. 17550	Present law	H.R. 17550	Present law	H.R. 17550
Contribution rates for employer-employee, each:						
1970	4.2	4.2	0.6	0.6	4.8	4.8
1971-72	4.6	4.2	0.6	1.0	5.2	5.2
1973-74	5.0	4.2	.65	1.0	5.65	5.2
1975	5.0	5.0	.65	1.0	5.65	6.0
1976-79	5.0	5.0	.7	1.0	5.7	6.0
1980-86	5.0	5.5	.8	1.0	5.8	6.5
1987 and after	5.0	5.5	.9	1.0	5.9	6.5
Self-employed contribution rates:						
1970	6.3	6.3	0.6	0.6	6.9	6.9
1971-72	6.9	6.3	.6	1.0	7.5	7.3
1973-74	7.0	6.3	.65	1.0	7.65	7.3
1975	7.0	7.0	.65	1.0	7.65	8.0
1976-79	7.0	7.0	.7	1.0	7.7	8.0
1980-86	7.0	7.0	.8	1.0	7.8	8.0
1987 and after	7.0	7.0	.9	1.0	7.9	8.0

The portion of social security contributions that is allocated to the disability insurance trust fund would be revised (as to the combined employer-employee rate) from 1.10 percent of taxable wages for 1970 and after (as in present law) to 0.90 of 1 percent for 1971 through 1974, to 1.05 percent for 1975 through 1979, and to 1.15 percent in 1980 and after, with corresponding changes in the allocation of the self-employed contribution rates.

III. GENERAL DISCUSSION OF THE BILL

A. GENERAL DISCUSSION OF PROVISIONS RELATING TO THE CASH BENEFITS PROGRAM

1. 5-percent increase in benefits

Over the years your committee has taken action to maintain social security benefits at realistic and adequate levels. From time to time these benefits have been increased to take into account changes in the national economy—particularly changes in living costs, earnings levels, and living standards. The most recent of these increases was the 15-percent increase provided under the Social Security Amendments of 1969, which, although effective with respect to the benefits payable for January 1970, was first paid to beneficiaries in April of this year.

Your committee recommends a general benefit increase of 5 percent effective with the benefits payable for January 1971. At the time your committee recommended the 15-percent benefit increase, it saw "a pressing and urgent need" for a benefit increase "as quickly as possible." As the result of further deliberations, your committee now sees a need for an additional increase in benefits starting next year. Without claiming prescience, your committee believes that economic changes in the shortrun future will warrant a further benefit increase.

Under the present law monthly benefits for workers who retire at age 65 in 1971 will range from \$64 to \$193.70; under the bill these amounts would range from \$67.20 to \$203.40. Additional illustrations of the effect of the benefit increase are shown in the table below. The table also reflects some of the effect of another provision in the bill which would increase the earnings base to \$9,000, effective January 1,

1971. It should, however, be pointed out that in addition to the effects of the higher base reflected in the table, the higher creditable earnings under the new \$9,000 base would also result in higher average monthly wages which would help maintain a reasonable relationship between benefits and earnings for people who have earnings of more than the present \$7,800 maximum.

ILLUSTRATIVE MONTHLY BENEFITS PAYABLE UNDER PRESENT LAW AND UNDER H.R. 17550

Average monthly earnings ¹	Worker ²		Man and wife ^{2,3}		Widow and 2 children	
	Present law	H.R. 17550	Present law	H.R. 17550	Present law	H.R. 17550 ⁴
\$76-----	\$64. 00	\$67. 20	\$96. 00	\$100. 80	\$96. 00	\$100. 80
150-----	101. 70	106. 80	152. 60	160. 20	152. 60	160. 20
250-----	132. 30	139. 00	198. 50	208. 50	202. 40	208. 50
350-----	161. 50	169. 60	242. 30	254. 40	280. 80	280. 80
450-----	189. 80	199. 30	284. 70	299. 00	354. 40	354. 40
550-----	218. 40	229. 40	327. 60	344. 10	395. 60	395. 60
650-----	250. 70	\$263. 30	376. 10	395. 00	434. 40	434. 40
750-----	(⁵)	\$283. 00	(⁵)	424. 50	(⁵)	474. 40

¹ Figured generally over 5 less than the number of years elapsing after 1936 or 1950, or age 21, if later, and up to the year of death, disability, or attainment of age 65 for men (62 under the bill) and 62 for women.

² For a worker who is disabled or who is age 65 or older at the time of retirement and a wife age 65 or older at the time when she comes on the benefit rolls.

³ Survivor benefit amounts for a widow and 1 child or for 2 parents would be the same as the benefits for a man and wife.

⁴ For families already on the benefit rolls who are affected by the maximum benefit provisions, the amounts payable under the bill would in some cases be somewhat higher than those shown here.

⁵ Generally payable to people who retire at age 65 in 2006.

⁶ Not applicable, since the highest possible average earnings is \$650.

Some 25.6 million beneficiaries on the rolls in January 1971 would have their benefits increased under this provision. An estimated \$1.7 billion in additional benefits would be paid in the first 12 months.

2. Increase in special payments to certain people age 72 or older

The bill would also increase by 5 percent the special cash payments that are made under present law to people age 72 and older who are not insured for regular cash benefits under the social security system.

Under the 1965 amendments to the social security law, special monthly payments were provided for certain people who reached age 72 before 1969 on the basis of less work than is needed to qualify for regular cash benefits. The cost of the payments under this provision is met out of the old-age and survivors insurance trust fund.

Special monthly payments were also provided, under an amendment to the law enacted in 1966, for persons with no social security credits who reached age 72 before 1968 and for persons who reach age 72 after 1968 and before 1972 who have earned credit for some work but who do not qualify for payments under the 1965 amendments. Payments made under the 1966 amendments are reduced by the amount of any pension, retirement benefit, or annuity that a person is receiving under any other governmental pension system. Also, the payments are suspended for any month for which the person receives a payment under a federally aided public assistance program. Most of the cost of the payments to persons under this provision is met from general revenues.

Under the 5-percent increase provided in the bill, the payments under both of these special transitional provisions would be increased from \$46 to \$48.30 for an individual and from \$69 to \$72.50 for a couple, effective for January 1971. As a result, about 6,000 people who do not now get the special payments would qualify for some pay-

ments, and about 620,000 people would qualify for higher payments under this provision. An estimated \$17 million in additional payments would be paid out in the first 12 months; about \$15 million of this amount would be paid from general revenues.

3. Liberalization of the retirement test

Under present law, if a beneficiary under age 72 earns more than \$1,680 in a year, \$1 less in benefits is paid for each \$2 of earnings between \$1,680 and \$2,880 and for each \$1 of earnings above \$2,880. However, full benefits are paid, regardless of the amount of annual earnings, for any month in which the beneficiary neither works for wages of more than \$140 nor renders substantial services in self-employment. Under the bill, beginning 1971, a beneficiary would receive the full amount of his benefits each month if his annual earnings did not exceed \$2,000; his benefit would be reduced by \$1 for each \$2 of earnings between \$2,000 and \$3,200 and for each \$1 thereafter. The bill would increase from \$140 to \$166.66 the amount of wages a beneficiary may earn in a given month and still get full benefits for that month. These changes would update the retirement test to take into account the increase in earnings levels since the present \$1,680 annual exempt amount became effective (beginning 1968) and make possible an increase in annual income for many of the beneficiaries who work.

The bill would also change the retirement test as it applies in the year in which a worker reaches age 72. Under present law, benefits are not withheld under the test for months when the person is age 72 or older. However, in the year in which a beneficiary reaches age 72, earnings in and after the month in which he reaches age 72 are counted in determining whether benefits are reduced or withheld for the months before he reached age 72. Many beneficiaries believe that earnings after they reach age 72 are not counted under the retirement test; as a result, they are entitled to less in benefits than they expected and may find that they have been overpaid because of this misunderstanding. Your committee's bill would provide that only amounts earned before the month in which the beneficiary became 72 would be used in determining his earnings for the year for retirement test purposes. In applying this provision the earnings of a self-employed beneficiary would be prorated equitably to the months in his taxable year.

4. Increase in widows' and widowers' insurance benefits

A factor which must be taken into account in considering whether the levels of social security benefits are adequate at any given time is the relationship of survivors' benefits to the worker's retirement benefit. In this connection your committee examined the benefits paid to older widows and found that the benefits paid to these people were not adequate because under the present law the most that can be paid to a widow is 82.5 percent of the retirement benefit which would be paid to her husband if he started getting benefits at or after age 65.

When social security benefits were first provided for widows by the Social Security Amendments of 1939 they were set at 75 percent of the worker's retirement benefit. This computation was based on the idea that a widow should receive one-half of the combined benefit which would have been paid to her and her husband had both been

entitled to benefits. Later, this amount was increased by 10 percent, to 82.5 percent, where it has remained up to the present.

It is your committee's opinion that the reasons for setting widow's benefits at their present level are no longer valid and that in the light of present conditions there is no reason for paying aged widows less than the amount which would be paid to their husbands as retirement benefits. Currently, the average benefit for an aged widow is \$101 a month, while the average benefit for a retired worker is \$117. In addition, surveys of social security beneficiaries have shown that, on the average, women getting aged widow's benefits have less income other than social security than most other beneficiaries.

Your committee's bill would provide an increase in the benefits of widows and widowers who become entitled to benefits after reaching age 62. Under the bill, the benefit for a widow who becomes entitled to widow's benefits at or after age 65 would be increased from 82½ percent (payable under present law) to 100 percent of the amount her deceased husband would receive if his benefits started at or after age 65. For widows becoming entitled to widow's benefits between ages 62 and 65, the 100-percent amount would be reduced. For widows who start getting benefits before age 62, the amount would be approximately the same as, and in no case less than, is payable under present law.

Under the bill, as under present law, the benefit for a widow who is age 62 or older when she starts getting benefits and who is the only survivor getting benefits would not be less than the minimum benefit payable to a retired worker at age 65. The benefit for a widow who starts getting benefits before 62 and who is the only survivor getting benefits would be the minimum benefit reduced only because of the number of months before age 62 for which the benefit is paid.

The changes made with respect to widows would also apply to eligible dependent widowers.

ILLUSTRATIVE MONTHLY BENEFITS FOR WIDOWS AND WIDOWERS WHO BECOME ENTITLED AT OR AFTER AGE 65
UNDER PRESENT LAW AND UNDER H.R. 17550.

Average monthly earnings	Present law	H.R. 17550		Total benefit payable
		Additional amount resulting from general benefit increase	Additional amount resulting from widow's benefit increase	
\$76.00-----	\$64.00	\$3.20	-----	\$67.20
150.00-----	84.00	4.20	\$18.60	106.80
250.00-----	109.20	5.50	24.30	139.00
350.00-----	133.30	6.70	29.60	169.60
450.00-----	156.60	7.90	34.80	199.30
550.00-----	180.20	9.10	40.10	229.40
650.00-----	206.90	10.40	46.00	263.30
750.00-----	(1)	(1)	(1)	283.00

¹ Not applicable, since the highest average earnings amount now possible is \$650.

Your committee's intention is to provide the same amount—100 percent—for both the worker and the widow when the benefits start at or after age 65, and to provide reduced benefits in both cases when benefits begin before age 65. However, because of the necessity of gearing in the widow's benefits between the ages of 62 and 65 with the higher amount provided under present law for a widow at age 62, as

compared with the amount provided for a worker age 62, the reduction for widows and widowers who receive benefits beginning before age 65 is slightly different than the reduction for workers.

The increase in benefits for widows and dependent widowers would be effective for January 1971. Widows and widowers who are receiving benefits at that time and who would get higher amounts as a result of the provisions would have their benefits recomputed.

Some 3.3 million widows and widowers on the rolls at the end of January 1971 would receive higher benefits under this provision, and \$700 million in additional benefit payments would be made in the first 12 months.

5. Dependent widowers' benefits at age 60

Under present law, an aged widow can become entitled to widows' insurance benefits at age 60, but an aged dependent widower cannot become entitled to dependent widowers' benefits until age 62. This situation results from the 1965 amendments, which lowered the age of eligibility for widows from 62 to 60 but did not change the age of eligibility for dependent widowers.

Your committee believes that the age of eligibility should be the same for aged dependent widowers as it is now for aged widows. Accordingly, the bill would lower the age of eligibility for aged dependent widowers' benefits from 62 to 60. The benefits payable to an aged dependent widower who starts getting benefits before age 62 would be actuarially reduced, as are the benefits under present law for aged widows who come on the benefit rolls before age 62.

6. Age-62 computation point for men

Under present law, retirement benefits for men are figured differently, and less advantageously, than are the benefits for women. For a man the period for determining the number of years of earnings that are used in figuring the average monthly earnings on which his benefits are based ends with the beginning of the year in which he reaches age 65. For a woman the period ends with the beginning of the year in which she reaches age 62. Thus 3 more years are used for a man than are used for a woman of the same age.

This difference in the treatment of men and women under the program can result in significantly lower benefits being paid to a retired man than are paid to a retired woman with the same earnings. For example, a man and a woman each reach age 65 and retire in 1971. They each have maximum creditable earnings under the program in each year up to 1971. The woman's benefit beginning at age 65 would be \$200.30 a month under present law while the man's benefit would be only \$193.70 a month. If both workers reach age 62 in 1971, the woman's benefit would be \$155 a month while the man's benefit would be only \$148.80 a month.

The bill would change the way a man's retirement benefit is figured to make the computation the same as the computation of a woman's benefit. As a result the retirement benefits that a man would be paid would be the same as the benefits to a woman of the same age and with the same earnings. The change would result in higher retirement benefits for most men than are provided under present law. It would also result in higher benefits for dependents of retired workers and for the survivors of men who died after age 62.

The provision to shorten the computation period for men would be effective for benefits for January 1971. It would apply not only to those who come on the benefit rolls in and after January 1971 but also to those who are on the benefit rolls when the provision becomes effective. Benefits for those on the benefit rolls before 1971 would be re-computed under the new provision and, in many cases, the increased benefits would be paid beginning with payments for January 1971, payable in February. Some beneficiaries who have earnings in 1969 and whose benefits have to be refigured to take account of those additional earnings might not be paid their increased benefits until later in 1971 because of the time required to make the necessary computations but the payments would be made retroactive to January 1971.

The amount of social security credit that a worker must have to be insured for benefits is also determined differently, under present law, for men than for women. Again, the ending point for determining benefit eligibility for a man is the year in which he reaches age 65, while for a woman it is the year in which she reaches age 62. Your committee's bill would make the ending point age 62 for both men and women and allow men to become fully insured on the basis of fewer quarters of coverage than are now required. This change would be effective for January 1971.

An estimated 10.2 million people on the rolls on the effective date would receive larger benefits as a result of these changes, and in addition, 60,000 persons—workers and their dependents not eligible under present law—would be added to the rolls in the first 12 months. In the first 12 months an additional \$925 million in benefits would be paid out.

7. Election to receive actuarially reduced benefits

Under present law, a married person who has worked and is eligible for both an old-age insurance benefit as a retired worker and a wife's or husband's insurance benefit as the spouse of a retired worker cannot apply for just one of the benefits; when he applies for one he is deemed to have applied for both. As a result, such a person who claims benefits before age 65 has both of his benefits actuarially reduced.

Also under present law a wife who has worked and becomes eligible for an old-age insurance benefit based on her own earnings, who takes that benefit before age 65, and who later becomes eligible for a wife's benefit when her husband applies for his retirement benefit can get a lower wife's benefit (on account of the reduction that was made in her old-age insurance benefit because it was paid before age 65) than does a wife who never worked under the program. (This situation does not occur under present law when a woman getting wife's insurance benefits later becomes eligible for an old-age insurance benefit; the reduction in her wife's benefit is disregarded in figuring the amount of her old-age insurance benefit.) Present law also provides that if a woman takes a widow's insurance benefit before age 62 and later gets a disability or old-age insurance benefit, the later benefit is reduced to take account of the prior receipt of the reduced widow's benefit.

Under the bill, the deemed filing provision would be removed from present law. A person eligible for benefits as a retired worker and also as a spouse could choose to take only one of the benefits and claim the other one later, or he could take both benefits at the same time.

Also under the bill the reduction that is made in one benefit would not lower the amount of a benefit that is taken later.

Some examples showing the effect of these changes in the law are as follows:

Example 1.—A woman is potentially eligible for an old-age benefit and a wife's benefit at age 62. Her unreduced old-age benefit, payable if the benefit begins at or after age 65, is \$78. Her husband's unreduced benefit is \$198. Her unreduced wife's benefit is \$21—one-half of her husband's \$198 benefit, or \$99 minus her own unreduced benefit of \$78. Her combined unreduced old-age benefit and wife's benefit would be \$99—her own benefit of \$78 plus her wife's benefit of \$21.

She applies for reduced benefits at age 62 and, under present law, must apply for both benefits. Her old-age benefit is 80 percent of \$78, or \$62.40. Her wife's benefit is 75 percent of \$21, or \$15.80. Her combined old-age benefit and wife's benefit beginning at age 62 is \$78.20.

Under the committee's bill she could restrict her application at age 62, take only one of her benefits and wait until later to file for the other. She could take her reduced old-age insurance benefit, get \$62.40 a month at age 62, and wait until age 65 to claim her wife's benefit, and get \$99 a month from age 65 on.

Example 2.—A woman is eligible for her own old-age insurance benefit at age 62. Her husband has not yet applied for benefits so she is not eligible for a wife's benefit. Her old-age insurance benefit at age 65 would be \$78; she chooses to take it at age 62 and gets a reduced benefit of \$62.40. When she reaches age 65, her husband retires, applies for benefits, and becomes entitled to an old-age benefit of \$198. She applies for wife's benefits and becomes entitled to a wife's benefit of \$21—one-half of her husband's \$198 benefit, or \$99, minus her own unreduced benefit of \$78. If she had not taken her own benefit at age 62, she would get \$99 a month under present law. Because she did take her own benefit at age 62, she can only get \$83.40 starting at age 65—\$62.40 plus \$21.

Under the bill, she would get a benefit of \$99 a month starting at age 65 notwithstanding the fact that she elected to take her reduced old-age benefit at age 62.

The new provisions would apply to people who become entitled to benefits for or after the sixth month after the month of enactment. People already on the benefit rolls when the provisions become effective could, upon request, have their benefits redetermined under the new provisions.

In some cases the application of this provision would mean that a beneficiary should not have been entitled to some of the benefits he had been paid. If these beneficiaries wish to be paid the higher benefits provided under the bill they would be required under a special repayment provision to repay the benefits they are no longer entitled to have been paid. The repayment would be accomplished by withholding payment of the amount of the increase in benefits that would occur under the provision until recovery is made of the excess of the amount the beneficiary was actually paid over the amount he would have been paid if the provision had been in effect at the time of his original application.

An illustration of how the recovery would be accomplished is as follows:

Consider the case discussed in the first example above. She could, under the provisions of the bill, request to have her benefit redetermined under the new provisions. As a result of this redetermination, her month of entitlement to wife's benefits could be changed from the month in which she reached age 62 to the month in which she reached age 65. With this change, the amount of her monthly benefit should have been \$62.40 (instead of \$78.20) a month from age 62 to age 65 and \$99 (instead of \$78.20) a month from age 65 on. She was paid \$78.20 a month from age 62 on, or \$15.80 a month too much from age 62 to age 65 and \$20.80 a month too little from age 65 on. Assume she is age 66 when the redetermination is made. If the bill had been in effect she would have been paid, for the 48 months from age 62 to age 66 for which she has been paid benefits, \$62.40 a month for the 36 months from age 62 to age 65, and \$99 a month for the 12 months from age 65 to age 66, for a total of \$3,434.40. She would actually have been paid \$78.20 a month for all 48 months, for a total of \$3,753.60. Thus she would have been paid a total of \$319.20 too much—\$3,753.60 that she did get paid less \$3,434.40 that she should have been paid. The \$20.80 increase in her benefit, from \$78.20 to \$99, would be withheld and not paid to her until the \$319.20 has been recovered—in about 16 months. From that point on she would get a monthly benefit of \$99. If she should die or become entitled to another benefit (for example, a widow's benefit based on her husband's earnings) before the \$319.20 is entirely recovered, the amount not yet recovered would be waived.

The bill would make no change in the provisions of present law under which a person entitled to both an old-age insurance benefit and a wife's or dependent husband's insurance benefit may not get both benefits in full. Under the law, a worker always gets the old-age insurance benefit he earns for himself; if that benefit is higher than the benefit he is potentially eligible for as a wife or dependent husband, the latter benefit is not payable. If the worker's old-age insurance benefit is less than the wife's or dependent husband's benefit payable on the spouse's earnings, the difference between the two benefits is paid as the wife's or dependent husband's benefit.

Approximately 100,000 beneficiaries on the rolls would be immediately affected by this provision, which would result in additional benefit payments estimated at \$10 million during the first 12 months.

8. Eliminate the support requirements for divorced women

Your committee is concerned that there are a number of divorced women who cannot qualify for social security benefits because they cannot meet the support requirement in the law. Benefits are payable to a divorced wife age 62 or older and a divorced widow age 60 or older if her marriage lasted 20 years before the divorce, and to a surviving divorced mother. In order to qualify for any of these benefits a divorced woman is required to show that: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from her former husband pursuant to a written agreement, or (3) there was a court order in effect providing for substantial contributions to her support by her former husband.

In some States the courts are prohibited from providing for alimony, and in these States a divorced woman is precluded from meeting the third support requirement. Even in States which allow alimony, the

court may have decided at the time of the divorce that the wife was not in need of financial support. Moreover, a divorced woman's eligibility for social security benefits may depend on the advice she received at the time of her divorce. If a woman accepted a property settlement in lieu of alimony, she could in effect have disqualified herself for divorced wife's, divorced widow's, or surviving divorced mother's benefits.

The intent of providing benefits to divorced women is to protect women whose marriages are dissolved when they are far along in years—particularly housewives who have not been able to work and earn social security protection of their own. Your committee believes that the support requirements of the law have operated to deprive some divorced women of the protection they should have received and, therefore, recommends that these requirements be eliminated, effective January 1, 1971.

9. Disability insured status for individuals who are blind

To be insured for disability protection under present law, a worker must be fully insured and meet a requirement of substantial recent covered work. Generally, to meet the latter requirement, a disabled worker needs at least 20 quarters of social security coverage during the period of 40 calendar quarters ending with the quarter in which he became disabled; a special provision takes into account that workers who are disabled while young may have been in the work force for a relatively short time.

Your committee's bill would extend social security disability protection to additional blind persons by eliminating for them the requirement of recent attachment to covered work. A blind person would be insured for social security disability benefits and a disability freeze if he is fully insured—that is, he has quarters of coverage, acquired at any time, equal to the number of years elapsed after 1950 (or the year he reached age 21, if later) and up to the year in which he became disabled, except that he could not be insured with less than 6 quarters of coverage and would in no case need more than 40 quarters of coverage to be insured. This requirement would permit blind persons to be insured for disability protection on a basis comparable to that for retirement and survivor benefit protection. This seems to the committee to be a more reasonable basis for qualifying for disability protection on the part of a blind individual, who faces employment problems not encountered by sighted persons.

The provision would be effective for January 1971. About 30,000 persons—blind workers and their dependents—would become immediately eligible for monthly benefits. About \$25 million in additional benefits would be paid out during the first 12 months.

10. Wage credits for members of the uniformed services

Under present law, social security coverage is provided on a contributory basis for those serving in the uniformed services in years after 1956, but it is limited to a serviceman's basic pay and does not reflect the cash value of wages in kind, such as food and shelter, which is generally covered under social security with respect to other employment. The 1967 social security amendments therefore provided (in addition to the contributory coverage of basic pay) noncontributory wage credits, up to \$100 for each month of military service after 1967, to take account of the wages in kind that servicemen receive.

The bill would extend the 1967 provision to cover service during the period 1957-67. This would assure realistic social security credit for service on active duty for all years that military service has been covered under social security, and would avoid the serious impairment of social security protection that now exists for some workers (and their families) whose benefits are based on only basic pay for years of military service during the period from 1957 through 1967.

The cost of additional social security benefits that would be paid as a result of the enactment of this provision would be financed from general revenues, on the same basis as the benefits resulting from the present noncontributory wage credits for years after 1967.

11. Application for disability benefits after disabled worker's death

Under present law, an application must be filed with the Social Security Administration to establish entitlement to social security disability insurance benefits by the disabled worker or, if he is unable to file an application, by another person on his behalf. In either event, entitlement to disability insurance benefits cannot be established unless the application is filed during the worker's lifetime.

In most cases a timely application is filed by or on behalf of a disabled worker who meets the other eligibility conditions of the law, so that the benefit rights of both the disabled worker and his dependents are protected. However, in a relatively few cases a disabled worker who would have been eligible for benefits dies before an application is filed and his disability benefit rights are lost. As a result, the living expenses and additional costs incurred by the disabled worker during the period of his disablement may remain unpaid and become obligations of his survivors.

Your committee has therefore included in the bill a provision which would permit disability insurance benefits to be paid if an application is filed within 3 months after the month of the death of a disabled worker. Benefit payments which would have been payable upon application of the disabled worker would then be payable for up to twelve months prior to the month in which an application is filed. An application filed within the extended period would also permit entitlement to dependent's benefits to be established.

The provision would apply in cases of deaths occurring in or after the year of enactment. In cases in which the disabled worker died in the year the bill is enacted but prior to enactment of the bill, an application could be filed within three months after the date of enactment and the application would be deemed to have been filed in the month of death.

12. Disability benefits affected by the receipt of workmen's compensation

Your committee's bill would modify present provisions under which social security disability benefits must be reduced in some cases where the disabled worker is also receiving workmen's compensation.

Under present law, when a disabled worker qualifies for both workmen's compensation and social security disability benefits, the social security benefits payable to him and his family are reduced by the amount, if any, that the total monthly benefits payable under the two programs exceed 80 percent of his average current earnings before he became disabled. A worker's average current earnings for this purpose are the larger of (a) the average monthly earnings used for computing his social security benefits, or (b) his average monthly earnings in employment or self-employment covered by social security

during the 5 consecutive years of highest covered earnings after 1950, computed without regard to the limitations which specify a maximum amount of earnings creditable and taxable under social security.

The objective of these provisions is to avoid the payment of combined amounts of social security benefits and workmen's compensation payments that would be excessive in comparison with the beneficiary's earnings before he became disabled. Your committee recognizes, however, that workmen's compensation is not solely a replacement of lost earnings but is, in part, compensation for pain and loss of function for which the disabled worker might otherwise secure recompense through legal action against his employer. It should, therefore, not be necessary to limit a worker's combined social security disability benefits and workmen's compensation payments to less than he earned before becoming disabled. Moreover, your committee has concluded that the present provisions are unduly restrictive and result in hardship for some disabled workers and their families. A worker's total disability will usually give rise to substantial expenses in addition to the family's continuing regular expenditures. Limiting the combined benefits that are payable to 80 percent of average current earnings has in many instances caused a significant reduction in the family's standard of living in comparison with the level attained by the worker at the time of disablement. A worker's average current earnings are calculated for purposes of these provisions on the basis of his earnings over a protracted period of time rather than his earnings just before disablement. Thus, restricting the family benefits to 80 percent of average current earnings may result in payment of an amount below 80 percent of the earnings level the worker had reached at the time he became disabled. Your committee believes that the allowable amount of combined workmen's compensation and social security disability benefits should be increased. The bill would therefore raise the combined payments allowable to 100 percent of the worker's average current earnings.

13. Coverage of Federal Home Loan Bank employees

The Social Security Amendments of 1956 provided for coverage of employees of the Federal Home Loan Banks on condition that their retirement system be coordinated with social security and that the plan for coordination be submitted to the Secretary of Health, Education, and Welfare and approved by him before July 1, 1957. This condition was not fulfilled within the prescribed time.

The Federal Home Loan Bank Board has again requested that social security coverage be extended to the employees of Federal Home Loan Banks, who number approximately 500. These employees are eligible for retirement coverage under the Savings Association Retirement Fund which your committee is informed now provides coverage that is coordinated with the benefits provided under the social security program.

The bill would extend coverage to all current and future employees of the Federal Home Loan Banks for years after 1970. Persons who are Bank employees on January 1, 1971, would also have their service after 1965 covered, but only if the social security contributions on account of such service are paid by July 1, 1971, or by such later date as may be provided under an agreement entered into between the Banks and the Secretary of the Treasury.

14. Coverage of policemen and firemen in Idaho

The bill would make applicable to the State of Idaho the provision in the Social Security Act which makes social security coverage available, in certain jurisdictions specifically named in the law, to policemen and firemen who are in positions covered under a State or local retirement system, on much the same basis as to other persons under retirement systems. Under present law, the provision applies to 19 States, Puerto Rico, and to all interstate instrumentalities. The 19 States which are now included in the provision are Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington.

In Idaho and in other States not named in the law, social security coverage is not available to policemen who are in positions covered under a State or local retirement system. It is available for firemen under a retirement system in these States, but only if special conditions set forth in the Federal law are met. The Governor of the State must certify that the overall benefit protection of the group of firemen which would be brought under coverage would be improved by reason of the extension of coverage to the group, and coverage can be extended only by means of a referendum in which only firemen may vote.

15. Coverage of certain hospital employees in New Mexico

Your committee's bill would permit the State of New Mexico, at any time prior to January 1, 1971, to provide social security coverage, under its coverage agreement with the Secretary of Health, Education, and Welfare, for employees of certain public hospitals without regard to the provisions of the Social Security Act which specify the conditions under which a State may bring a group of employees under social security coverage.

As a result of a misunderstanding within the State, certain hospital employees were covered under the New Mexico Public Employees Retirement Association for a short period of time, although the coverage was unintended as far as the hospital and the hospital employees were concerned. This period of coverage under the State retirement system presents a serious obstacle to obtaining social security coverage for the employees in question because of the provisions of the Social Security Act that are designed to protect the rights of such employees against the replacement of coverage under a State or local government retirement system by social security coverage. The unusual situation in New Mexico is not the type of situation to which these provisions designed to provide safeguards for retirement system members were directed.

16. Childhood disability benefits for those disabled before age 22

Your committee's bill would improve disability protection for persons who become totally disabled before reaching an age at which they are likely to be self-supporting. Under present law, social security benefits are provided for the child of an insured deceased, disabled, or retired worker until the child attains age 18 or, if attending school, age 22. Also, a son or daughter of an insured worker can qualify for childhood disability benefits if he has been continuously totally disabled since before age 18 and is still disabled after the worker dies or becomes entitled to social security benefits. Your committee's bill would permit the payment of childhood disability benefits to such a son or daughter who becomes totally disabled before age 22.

When total disability arises between ages 18 and 22 the disabled son or daughter generally continues to be dependent on his parents. Your committee believes that it is appropriate and desirable to provide social security benefits in such cases should the insured parent die, become disabled, or retire.

The provision for benefits for people disabled since before age 22 would be applicable not only prospectively but also in the case of people who have already met the conditions proposed for entitlement to benefits and would be effective with respect to benefits for months after December 1970. About 13,000 people—disabled children and their mothers—would immediately become eligible for benefits. About \$10 million in additional benefits would be paid out during the first 12 months.

17. Penalty for furnishing false information to obtain a social security number

Under present law, criminal penalties are provided for any person who makes a false representation to obtain payment of social security benefits which are not due him. These penalties may be applied, for example, if a person attempts to get benefits based on his own earnings under more than one social security number, or to avoid having his benefits withheld under the retirement test by drawing benefits under one number while continuing to work for high earnings under a false name and another number, or to continue to draw disability benefits while engaged in substantial gainful employment under another name and number. Penalties are not provided in the social security law for those individuals who give false information in order to secure multiple social security numbers with an intent to conceal their true identities.

The use of false names, aided by a social security number issued in false names, has led to a number of problems in both private business and the administration of Government programs. Therefore, the bill would provide criminal penalties if an individual, with intent to deceive the Secretary of Health, Education, and Welfare as to his true identity knowingly and willfully furnishes false information on an application for a social security number for the purpose of obtaining more than one number or of establishing a social security record under a different name. The penalty would not be applicable, however, if the person obtaining more than one social security number provides sufficient information to permit the Social Security Administration to identify all the numbers issued to such person so that all of his wage credits may be combined.

18. Guarantee that no family would have its total family benefits decreased as a result of an increase in the worker's benefit

In the past when general benefit increases have been enacted it has been possible, in certain cases, for a family that comes on the benefit rolls after the increase is effective but is entitled to retroactive benefits in the period before the increase is effective to have the total family benefits decreased slightly. Such a decrease can also occur under present law when a worker's benefit is increased as a result of a recomputation of his benefit amount to include additional earnings. Those decreases occur in cases where the family maximum provision applies and the worker's benefit is actuarially reduced (because it started before age 65).

A special provision was included in the 1969 amendments to prevent a decrease in total family benefits from occurring under the general benefit increase that was included in those amendments. But the provision was only temporary in effect—it applied only to the general benefit increase under the 1969 amendments, and did not apply to earnings recomputation cases. There is a need, therefore, for a permanent provision that would apply to future general benefit increases and also to increases resulting from earnings recomputations. Such a provision is included in your committee's bill.

Under the provision, no family would have its total family benefits decreased because of an increase in the worker's benefit resulting from the 5-percent general benefit increase that would be provided by the bill or from any general benefit increase that may be enacted in the future or from a recomputation of the worker's benefit to include additional earnings.

B. GENERAL DISCUSSION OF MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROVISIONS

1. Coverage under medicare program

(a) *Payment under the medicare program to individuals covered by Federal employees health benefits program.*—Under present law, Federal employees and retirees age 65 and over who are enrolled for Federal employees health benefits (FEHB) are also covered under the medicare hospital insurance plan (part A) if they have worked in employment covered by social security or railroad retirement and are eligible for monthly cash benefits under these programs. In addition, Federal employees, whether or not eligible for part A benefits, may enroll in the medicare voluntary supplementary medical insurance plan (part B) which is available to essentially all persons age 65 and over. Part A hospital insurance protection under medicare is earned during a person's working years through a separate tax on his earnings and no payments are made by those entitled to benefits after they have stopped working. Part B medical insurance protection is available at 50 percent of cost, for which the enrollee pays a monthly premium—currently \$4, and due to be \$5.30 in July 1970—matched by the Federal Government.

In contrast, persons who are eligible for health insurance protection under a FEHB plan continue to pay the same premium rates for their coverage after retirement as they did when they were active employees (although the coverage may be more valuable since older people use more medical services). The Federal Government currently pays about 24 percent of the overall cost of FEHB protection.

When the medicare program was enacted in 1965, it was intended that it would provide basic health insurance protection for people age 65 and over and that it would pay its benefits in full without regard to any other benefits that might be payable under an employee health benefits plan. At the same time, it was expected that such plans would adjust their benefit policies to complement the protection provided under medicare rather than duplicating the benefits.

Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over (active or retired) so that such protection would be supplementary to medicare benefits.

Although most Federal employment covered by a Federal staff retirement system is excluded from social security coverage, many Federal employees become insured under social security on the basis of other employment. About 50 percent of retired and active Federal employees age 65 and over are entitled to hospital insurance benefits under medicare.

Several problems arise under the present situation. The FEHB plans cover many of the same health care expenses that are covered under medicare. In cases where health care expenses are covered under both medicare and a Federal employee plan, the medicare benefits are paid first, and the Federal employee plan then pays its benefits in an amount which, when added to the benefits payable under medicare, may not exceed 100 percent of the expenses allowable under the FEHB plan.

A Federal employee who is covered under a high-option FEHB plan as well as the medicare plans has somewhat better protection than is afforded under the FEHB plan alone. But, because of the nonduplication clauses in the FEHB contracts, he does not derive the full value of the protection of the FEHB contracts. If a Federal retiree entitled under medicare cancels his enrollment under a FEHB plan because of the high total cost of his health care protection, he will lose the high level of protection he previously enjoyed under the FEHB program at an age where his health care costs can be expected to increase substantially.

Federal retirees and employees who are covered under an FEHB plan generally do not find it advantageous to enroll in the medicare voluntary supplementary medical insurance plan, because of the overlapping of FEHB benefits and benefits under the supplementary plan. Thus, Federal retirees and employees do not receive the advantage, available to virtually all other persons age 65 and over, of the 50-percent Government contribution toward the cost of the protection under the supplementary medical insurance program.

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB, your committee's bill would provide that effective January 1, 1972, the medicare program (both parts A and B) would not pay for any otherwise covered service if such service is covered under a FEHB plan. This provision would not go into effect (or would be suspended, if already in effect) if the Secretary of Health, Education, and Welfare certifies that the FEHB program has been so modified as to assure that there is available to each Federal employee or retiree age 65 and over one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare, and the protection of part B alone and that the Government is making a contribution toward the health insurance of each Federal employee or retiree age 65 and over, which is at least equal to the contribution it makes for high option coverage under Government-wide FEHB plans. This contribution could be in the form of a Federal contribution toward the supplementary FEHB protection or a payment to or on behalf of such employee or retiree to offset the cost of his purchase of medicare protection, or a combination of the two. It is the hope and the intent of your committee that the Secretary will be able to make this certification before January 1972.

(b) *Hospital insurance benefits for uninsured individuals not eligible under present transitional provision.*—Present law provides hospital insurance protection under the “special transitional provision” for people who are not qualified for cash benefits under the social security or railroad retirement program. (The provision excludes an active or retired Federal employee, or the spouse of such an employee, who is covered or could have been covered under the provisions of the Federal Employees Health Benefits Act of 1959; aliens residing in the United States for less than 5 years; and people who have been convicted of a crime against the security of the United States, including sabotage, espionage, treason, etc.) The “special transitional provision” covers people who are not qualified for cash benefits under the social security or railroad retirement program and who reached age 65 before 1968 even though they had no work under social security (or in the railroad industry). Those who attained or will attain age 65 after 1967 must have had specified amounts of work under these programs in order to be eligible for hospital insurance protection. The transitional provision will phase out as of 1974 as persons attaining age 65 in those years must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

Since the transitional provision is designed to provide hospital insurance coverage for only a part (though a large part) of the uninsured aged and to eventually phase out, a portion of the aged, though small in number (as of January 1, 1970, this portion numbered approximately 305,000 or 1½ percent of the aged population), are and will be, for one reason or another, excluded from hospital insurance coverage. (The 305,000 people include 55,000 recent immigrants, who would continue to be excluded from coverage; 145,000 active or retired Federal employees, who are not eligible for the transitional provisions; and 105,000 others.) Although these ineligible include a substantial number of people who were eligible for social security coverage but who did not elect (or whose employers did not elect) to be covered (including employees of State and local governments), they also include several other groups: (1) wives who have never worked under covered employment and whose husbands are eligible for hospital insurance under the transitional provision, (2) women who are not insured on their own account and who cannot qualify for dependent's benefits (such as dependent aged sisters of insured workers and the dependents of uninsured workers), and (3) workers, such as agricultural and domestic workers, whose earnings may have been so low or sporadic they were unable to acquire insured status.

Further, it has become very difficult for many in this group to obtain private hospital insurance comparable to coverage under medicare. Since the passage of the medicare law, private insurance companies have generally changed their hospital insurance plans available to people age 65 and over to make their coverage complementary to medicare. While there is generally some type of hospital insurance available to persons age 65 and over, most of that which is offered is in the form of specified cash payment insurance, paying from \$25 to \$200 per week for limited periods of hospitalization. Few private health insurance companies offer their regular hospital expense plans to the aged.

Your committee's bill would make available hospital insurance coverage on a voluntary basis to persons age 65 and over who are not entitled to such coverage under existing law. A State or any other public or private organization would be permitted to purchase such pro-

tection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed by those who elect to enroll for this protection. Enrollees would pay a monthly premium based on the cost of hospital insurance protection for the uninsured group; such premium would be \$27 a month beginning with January 1971 and up to and including June 1972, and would be recomputed each year and increased in the same proportion as the inpatient hospital deductible. The same restrictions on enrollment and reenrollment (including a 10-percent-per-year charge for late enrollment) would apply as now apply to enrollment for supplementary medical insurance (including the changes in such enrollment provisions made by other provisions in the bill). Aliens who have been convicted of certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

Your committee's bill also would require that in order for persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. Those persons who have failed to enroll for supplementary medical insurance within the 3-year enrollment limit as prescribed by present law would be able, under another provision in your committee's bill to meet this requirement since they would no longer be excluded from enrolling for supplementary medical insurance. If a person terminates his supplementary medical insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date as his supplementary medical insurance termination. Your committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

The effective date for coverage provided under this provision would be January 1, 1971.

2. Improvements in the operating effectiveness of the medicare, medicaid, and maternal and child health programs

(a) *Limitation on Federal participation for capital expenditures.*— Under title XVIII depreciation on buildings and equipment, and interest on loans used to acquire them, are reimbursable as part of the cost of providing services to medicare beneficiaries. Such reimbursement is paid without regard to whether the items were constructed or purchased in conformity with any type of health facility planning requirement. Similarly, reimbursement on a cost basis for inpatient hospital services provided under titles V (maternal and child health) and XIX (medicaid) of the Social Security Act includes a recognition of certain capital costs without regard to conformance to planning requirements.

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive areawide planning for the development and utilization of all types of health care facilities. But the acceptance of the purposes of State and areawide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end result of such planning. Thus, while a significant amount of Federal money

is currently being expended under the comprehensive health planning provisions of the Public Health Service Act in the interest of furthering health facility planning at the State and local levels, Federal funds are being expended for health services provided under medicare, medicaid, and the maternal and child health programs without regard to whether the facilities providing the services are cooperating in such health facility planning. Your committee believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, your committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts, in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State, and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health care planning agencies. On the areawide level, 106 planning agencies are receiving Federal grants: 10 of such agencies are operational. It is estimated that 113 areawide planning agencies will be receiving grants by the end of June and that 35 of such agencies will be operational.

To avoid the use of Federal funds to support unjustified capital expenditures and to support health facility and health services planning activities in the various States, your committee's bill authorizes the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to certain capital expenditures that are determined to be inconsistent with State or local health facility plans. (Similar authority would be provided with respect to the Federal share of payment for inpatient hospital care under titles V and XIX.) Capital expenditures for the purposes of this provision include expenditures (1) for plant and equipment in excess of \$100,000; (2) which change the bed capacity of the institution; or (3) which substantially change the services provided by the institution. The Secretary would take such action on the basis of findings and recommendations submitted to him by various qualified planning agencies. If he determines, however, after consultation with an appropriate national advisory council, that a disallowance of capital expenses would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he would be authorized to allow such expenses.

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit

their findings and recommendations (along with those of other qualified planning agencies) with respect to proposed capital expenditures that are inconsistent with the plans developed by such agencies. (All such health facility and health services planning agencies must have governing bodies or advisory bodies at least half of whose members represent consumer interests.) The Secretary would be authorized to pay from the Federal Hospital Insurance Trust Fund the reasonable costs incurred by the planning agencies in preparing and forwarding findings and recommendations. The bill would in no way change the autonomy or authority of existing State or local planning agencies, or the relationships between such agencies, either within States or across State lines.

These limitations would be effective with respect to obligations for capital expenditures incurred after June 30, 1971, or earlier, if requested by the State.

(b) *Report on plan for prospective reimbursement; experiments and demonstration projects to develop incentives for economy in the provision of health services.*—Under present law, institutional providers furnishing covered services to medicare beneficiaries are paid on the basis of the reasonable cost of such services. Payment on this basis, with retroactive corrective adjustments, is consistent with the long history of public and private third party agency reimbursement for institutional health care on a cost basis. However, as experience under the medicare, medicaid, maternal and child health, and other third party programs has clearly demonstrated there is little incentive to contain costs or to produce the services in the most efficient and effective manner.

Your committee believes that payment determined on a prospective basis offers the promise of encouraging institutional policymakers and managers, through positive financial incentives, as well as the risk of possible loss inherent in that method, to plan, innovate and generally to manage effectively in order to achieve greater financial reward for the provider as well as a lower total cost to the programs involved. Prospective reimbursement differs from the present method of reimbursement in that a rate of payment is set in advance of the period over which the rate is to apply. The theory is that once the rate is set a provider will institute cost saving measures which will maximize the difference between its actual costs and the higher prospective rate. This difference could be expressed as the "profit." Of course, if the provider's costs turned out to be higher than the prospective rate, there would be a loss. Theoretically, this approach to reimbursement introduces incentives not present under the existing reimbursement method which, since it tends to pay whatever the costs turn out to be, provides no incentives for efficiency.

However, your committee is well aware that in considering such a fundamental change in the present reimbursement method, possible disadvantages as well as the potential advantages must be taken into account. While it is clear for example, that prospective rate setting will provide incentives for health care institutions to keep costs at a level no higher than the rates set, it is not clear that the rates set would

result in government reimbursement at levels lower than, or even as low as, that which would result under the present retroactive cost finding approach. Providers could be expected to press for a rate that would cover all the costs, including research costs and bad debts, as well as margins of safety in the prospective rates that might result in reimbursement—if their requests were met—in excess of the costs that would have been reimbursed under the present approach. Moreover, any excess of reimbursement over costs to voluntary providers would probably be used to expand services, and the new level of expenditures might be reflected in setting higher prospective rates for future years.

Also to be considered is the fact that under prospective reimbursement it will be necessary to take steps to assure that providers do not cut back on services necessary to quality care in order to keep actual costs down and thus increase the difference between costs and the prospective rate established. The development of adequate and widely-agreed-upon measures of quality of care will clearly be needed to provide that assurance and should be immediately developed by the Department.

In view of the far-ranging implications of such a change in the approach to reimbursement, your committee's bill provides for a period of experimentation under titles XVIII, XIX and V with various alternative methods and techniques of prospective reimbursement. It is the intent of your committee that experimentation be conducted with a view to developing and evaluating methods and techniques that will stimulate providers through positive financial incentives to use their facilities and personnel more efficiently, thereby reducing their own as well as program costs while maintaining or enhancing the quality of the health care provided.

The experiments and demonstration projects directed to be carried out under this provision are to be of sufficient scope and on a wide enough scale to give assurance that the results would obtain generally (but not so large or comprehensive as to commit the programs to any prospective payment system either locally or nationally). No experiment or demonstration project is to be undertaken by the Secretary until he consults with and takes into consideration the advice and recommendations of recognized specialists in the health care field who are qualified and competent to evaluate the feasibility of any given experiment or demonstration project.

Under your committee's bill, the Secretary would be required to submit to the Congress no later than July 1, 1972, a full report of the results of the experiments and demonstration projects, as well as an evaluation of the experience of other programs with respect to prospective reimbursement. The report is to include detailed recommendations with respect to the specific methods that might be used in the full implementation of a prospective reimbursement system.

Although recognizing the promise and potential offered by prospective reimbursement your committee does not wish to preclude experimentation with other forms of reimbursement. Your committee believes that a solid foundation of experience is required with all possible alternative forms of reimbursement before permanent changes can be made. The bill therefore includes authorization for the Sec-

retary of Health, Education, and Welfare to engage in experiments and demonstration projects involving negotiated rates, the use of rates established by a State for administration of one or more of its laws for payment or reimbursement to health facilities located in such State, and alternative methods of reimbursement with respect to the services of residents, interns, and supervisory physicians in teaching settings. Authority is also provided to make payments, on an experimental or demonstration project basis, to organizations and institutions for services which are not currently covered under titles V, XVIII, XIX, and which are incidental to services covered under the programs, if the inclusion of the additional services would offer the promise of program savings without any loss in the quality of care. The bill would also authorize experimentation with the use of areawide or communitywide utilization review and medical review mechanisms to determine whether they would bring about more effective controls over excessive utilization of services.

The Secretary is to submit to the Committee on Ways and Means and the Committee on Finance plans for each experiment or project, authorized under these provisions, a description, in detail, of its nature, methodology, and objectives. The intent is that there be an opportunity for congressional study before the experiment or project is put into operation.

These provisions will be effective upon enactment of the bill.

(c) *Limitations on coverage of costs under the medicare program.*—Your committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. Your committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. Your committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

In commenting on the wide variations in per diem direct expenses for hospitals in New York City, J. Douglas Colman, president of the Associated Hospital Service of New York, noted in a paper prepared in connection with the National Conference on Medical Costs held on June 27–28, 1967; that:

Some of the variations can be explained by varying characteristics of the patient census, by location, by scope of services offered, or by variations in the

efficiency of physical plant. But none of these, nor any combination of them, satisfactorily account for the range of variation shown. For example, the range for voluntary teaching hospitals in New York City alone is from 38 percent above to 20 percent below the median per diem cost for this group of hospitals. One must conclude that at least a part of this variation reflects variations in efficiency.

The data being cited by Mr. Colman indicated that direct costs of "hotel" services (food and room costs) in hospitals in New York City varied from \$17 to \$32 per patient day with a median of \$23, but three hospitals were at the level of \$30 or more, more than 25 percent above the median. Nursing service costs varied from \$11 to \$20 per patient day with a median of \$12 and the hospital with the highest nursing costs had nursing costs almost \$3 per day above the hospital with the next highest nursing costs.

Where the high costs do in fact flow from the provision of services in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not the committee's view that if patients desire unusually expensive service they should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly, when the high costs flow from inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy, should be encouraged to perform efficiently, and when they fail to do so should expect to suffer the financial consequences. Unfortunately, a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

The proposed new authority to set limits on costs recognized for certain classes of providers in various service areas differs from

existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary for the costs of of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made.

Your committee is aware of the magnitude of the task this proposal will impose on the Social Security Administration and on the other components of the Department of Health, Education, and Welfare that will be involved in implementing the authority it grants. Difficulties will be encountered as a result of deficiencies in the adequacy and timeliness of cost data and as a result of limitations in current methodology for comparing costs of health care institutions, measuring health care output and estimating the costs necessary to the efficient delivery of health care. On the other hand, your committee does not believe that the Congress should delay in enacting provisions controlling escalation of hospital and other health care costs until perfect methods of collecting and evaluating cost data are attained. What is intended by your committee's proposal is that limits on recognition of costs as reasonable under medicare, medicaid, and the child health programs be put into effect to the extent presently feasible and that these limits be refined and extended over time as developing cost data and methodology permits.

Your committee recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And your committee recognizes that these provisions will apply to a relatively quite small number of institutions. The data that is available for this purpose will often be less than perfectly reliable—for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year. Also, the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care—for example, the costs of the “hotel” services (food and room costs) provided by hospitals—the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical record costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits. In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity—particularly relatively high personnel costs in relation to patient loads where occupancy rates are low—in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

Providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community.

The determination of the cost of the excess items or services for which the beneficiary may be charged will be determined on the basis of costs previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from \$4 to \$9 a day with a median cost of \$5 a day and the limit for food services set by the Secretary for 1971 was \$7.20 a day, the hospital previously experiencing costs of \$9 a day could charge patients \$1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

These provisions would be effective with respect to accounting periods beginning after the enactment of the bill.

(d) *Limits on prevailing charge levels.*—Under present administrative policies under medicare, the prevailing limit on the reasonable charge for a service is intended, over the long run, to be generally about the 83d percentile of customary charges for that service in the physician's locality. To illustrate, if customary charges for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was \$150, 40 percent rendered by physicians who charge \$200, 40 percent rendered by physicians who charge \$250 and 5 percent rendered by physicians who charge \$300 and with the remaining 5 percent rendered by physicians charging in excess of \$300, the prevailing limit would be \$250, since this is the level that would cover at least 83 percent of the cases. However, if 15 percent, rather than 5 percent, of the services were rendered by physicians whose customary charge was at the \$300 level with 5 percent charging above that level, the prevailing charge limit would be \$300, since this would then be the level that would cover at least 83 percent of the cases.

Customary charges for services that are within the prevailing fee limit are generally recognized in full. (In a relatively small number of situations additional rules are used to judge the reasonableness of charges.)

Your committee believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned.

Under your committee's bill, the prevailing charges recognized for a locality could be increased in fiscal year 1972 and in later years only to the extent justified by indexes reflecting changes in the operating expenses of physicians and in earnings levels. What the bill provides is a limit on the increases that would be recognized on the basis of the other reasonable charge criteria. Increases in the customary charges of individual physicians and in the charges prevailing among physicians in a locality would continue to be recognized only on the basis of adequate evidence that such increases had been in effect for a period of time. The new ceiling on recognition of increases in prevailing charge limits that is provided would come into play only when the adjustments necessary to meet increases in the actual charges prevailing in a locality exceeded, in the aggregate, the level of increase justified by other changes in the economy.

The Secretary would establish the statistical methods that would be used to make the calculations to establish the limit on the increases allowed by this provision.

The base for the proposed economic indexes would be calendar year 1969. The increase in the indexes that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges above the original base that would be recognized in the fiscal year beginning after the end of that calendar year.

Initially, the Secretary would be expected to base the ceilings for recognition of increases in prevailing fee limits on presently available indexes of changes in consumer prices and earnings combined in a manner consistent with available data on the ratio of the expenses of practice to income from practice occurring among self-employed physicians as a group. If, for example, available data indicated that for self-employed physicians as a group, expenses of practice absorbed approximately 40 percent of gross receipts of practice (the proportion indicated for 1966 by data compiled by IRS from tax returns), the Secretary could determine that the maximum aggregate increase in prevailing charge levels that could be recognized in a carrier area would be 40 percent of the area increase in the BLS Consumer Price Index (all items less medical care) plus 60 percent of the area increase in the earnings reported to the social security program. The increase in the BLS Consumer Price Index (which includes a service component and other prices reflecting, to some degree, office salaries paid by physicians) would be considered to indicate the justifiable increase in fees to take account of increases in costs met by the physician in his practice and the increase in earnings would be considered to indicate the justifiable increase in fees to keep the physician's earnings in line with the earnings of others. Thus, if during calendar year 1970 the area increase in prices was 3 percent and the area increase in earnings was 5 percent, the allowable aggregate increase in prevailing charges recognized by the carrier in each locality during fiscal year 1972 would be 4.2 percent:

$$(.40 \times .03) + (.60 \times .05) = .042$$

The carrier would apply the prevailing charge criteria now in the law (but setting the prevailing charge limit at the 75th percentile of customary charges rather than at the 83d percentile permitted under present policies) to data on charges in calendar year 1970 to determine the increases in prevailing charges that it would be appropriate to recognize during fiscal year 1972. In the illustration cited earlier, where 20 percent of appendectomies in a locality were rendered by physicians who customarily charged \$300 or more and 80 percent of such services were rendered by physicians customarily charging at or below \$250, the prevailing charge level for that service would be \$250 (the level that would cover at least 75 percent of the cases), rather than the prevailing charge level of \$300 (the level that would cover at least 83 percent of the cases) that would be set under present policies. If the aggregate increase in prevailing charges so determined was less than 4.2 percent, the adjustments' would be permitted and the portion of the allowable aggregate increase not used in that fiscal year could be carried forward and used in future fiscal years. However, if the aggregate increase in prevailing charges found otherwise appropriate exceeded 4.2 percent, such increases would be reduced to the extent necessary to bring the aggregate of all increases within the 4.2 ceiling—that is, if the new prevailing charge limits that were indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges multiplied by the frequency of the related services in calendar year 1970 exceeded, in total, the prevailing charge limits indicated for fiscal year 1971 by the 75th percentile of calendar 1969 charges multiplied by the fre-

quency of the related services in calendar 1969 by 8.4 percent, then each of the prevailing charge increases indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges would be reduced by one-half so that the aggregate increase allowed would be within the 4.2 ceiling.

It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, your committee believes that the viability of the proposal does not depend on a great deal of further refinement. The objectives of the proposal could be attained with equity through the use of an approach such as that described above. This is so because the indexes are not to be applied on a procedure-by-procedure basis that would raise serious questions of equity in absence of refinements to take account of variations in the mix of factors of production among various types of medical services and to take account of changes in productivity with respect to various services. Rather, the indexes will operate as overall ceilings on prevailing fee level increases recognized in a carrier area under which adjustments permitted by the present customary and prevailing charge criteria could be made to take account of the shifting patterns and levels of actual charges in each locality. Thus, whether the new limit on prevailing charges will actually affect the determination of reasonable charges depends on the degree to which physicians' fees rise in the future. If the rise in fees in the aggregate was no more than the rise in prices and earnings, the rise in fees would be allowed in full.

Your committee believes it desirable to provide the Secretary with appropriate leadtime for implementation of the proposed ceilings on recognition of prevailing charge increases and to provide a conservative base for its application. For this reason, the committee bill includes an interim provision for fiscal year 1971 requiring, in effect, an extension of present policies to contain program costs that would be somewhat more restrictive than those presently anticipated. Under this interim provision the medical charge levels currently recognized as prevailing in a locality could be increased during fiscal year 1971 only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to bring the charge levels recognized as prevailing in a locality to the 75th percentile of the customary charges (weighted by frequency rendered) made for similar services in the same locality during calendar year 1969. However, if currently allowed charges exceed this 75th percentile, no decrease in charges would be required by the new legislation. And, as noted earlier, the prevailing charges calculated as representing the 75th percentile in calendar year 1969 will establish the base from which the rate increase in prevailing charge levels will be measured. The economic index that would go into effect starting with fiscal year 1972 would be applied to this base to establish limits in future years.

While tying the allowability of future increases in prevailing charges to general economic indicators is an appropriate method for reasonable charge determinations with respect to the services of physicians, your committee believes it would be inappropriate for reasonable charge determinations with respect to medical supplies, equipment, and services that do not generally vary in quality from one supplier to another.

This is so because no program purpose would be served by allowing charges in excess of the lowest levels at which supplies, equipment, or services can be readily obtained in a locality. For this reason, the committee bill permits deviation from generally applicable reasonable charge criteria where it is determined that medical supplies, equipment, and services do not generally vary in quality from one supplier to another.

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs in fiscal year 1971 and thereafter may not be made with respect to any amount paid for items and services that exceeds these new limits. This would be consistent with the situation in the present medicaid program.

The medicaid provisions of the Social Security Amendments of 1965 contained nothing which attempted to limit the charges by physicians that States could pay under their medicaid programs. States could and usually did set some type of limits of their own, typically much less than usual or customary charges. The Social Security Amendments of 1967 added a new medicaid provision which required that a State plan must provide assurances that "payments (including payment for any drugs under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." On June 30, 1969, HEW issued an interim regulation which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The HEW regulation stipulated that payments to providers would be limited to those received in January 1969, unless payments were below the 75th percentile of customary charges. States whose payment structures provided fees above the 75th percentile of customary charges were required to adjust their payments so that they did not exceed reasonable charges as determined under medicare. The regulation also stipulates that after July 1, 1970, States may request permission to increase fees paid to individual practitioners only if two conditions are met:

(1) The average percentage increase requested above the 75th percentile of customary charges on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or an alternative designed by the Secretary; and

(2) Evidence is clear that providers and the States have cooperatively established effective utilization review and quality control systems.

The proposed amendment is substantially along the lines of the present regulation.

(e) *Establishment of incentives for States to emphasize outpatient care under medicaid programs.*—Your committee has been concerned that ways be developed to improve the utilization of services under the medicaid program and to encourage more effective and lower cost patterns of service. The present law has a uniform Federal matching percentage applied to all forms of health services covered under the State medicaid plan. In order to encourage States to make more efficient use of health services, your committee's bill would create incentives to encourage outpatient services and disincentives for long stays in institutional settings. Specifically, the bill would provide for: (1) an

increase in the Federal matching percentage by 25 percent for outpatient hospital services, clinic services and home health services; (2) a decrease in the Federal percentage by one-third after the first 60 days of care (in a fiscal year) in a general or TB hospital; (3) a reduction in the Federal percentage by one-third after the first 90 days of care in a skilled nursing home; (4) a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after an additional 275 days of such care during an individual's lifetime; and (5) authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

These changes would be effective with respect to services furnished after January 1, 1971.

The proposal to increase the Federal matching for outpatient, clinic, and home health services is directed at encouraging the States to provide early diagnosis and treatment of illness, preventive services, and alternatives to institutional care intended to reduce the need for and use of inpatient services.

The proposed limitations on length of stay in mental institutions reflect the assumption that medical treatment of mental disease inpatients generally does not exceed three months, and for patients over 65 rarely continues beyond a year.

The limitations on care in general and TB hospitals are designed to encourage transfer of patients to less expensive facilities. They reflect the assumption that treatment in acute institutions is generally of short duration, rarely exceeding 60 days.

The reduction in matching for skilled nursing homes is directed toward early transfer of patients to alternative facilities (such as intermediate care facilities), and the provision granting authority to the Secretary to compute for reimbursement purposes a reasonable cost differential between cost of skilled nursing home services and cost of intermediate care facilities is designed to assure that supporting care in these alternate institutions results in decreased costs. These provisions reflect the concern that many patients remain in skilled nursing homes longer than necessary and that as a result program costs are unnecessarily increasing.

The bill would also make clear in the present statute that an intermediate care facility shall not include an institution for mental diseases or mental defects.

(f) *Payment for physician's services in the teaching setting.*—When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of how medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his

own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions, even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients. Early in 1969, onsite audits at a large mid-western county hospital staffed with many interns and residents disclosed a substantial overpayment. (The overpayment was later determined to be over \$1 million—repayment is now being made.) It was also clear that the same problem existed in a number of other large hospitals and, in April 1969, instructions were issued by HEW to amplify and clarify the original regulations by spelling out in considerable detail the conditions under which medicare can recognize a charge for services to patients whose care involved residents and interns.

When onsite review and other information had indicated a widespread misunderstanding over the billing requirements, HEW asked carriers in June 1969 to suspend payment for services rendered to teaching patients in all major teaching institutions where the carrier was not assured that the payments it was making were proper. The suspensions were temporary and intended to last only so long as carriers had time to investigate and review any major billing discrepancies. In all, about 240 hospitals have been suspended, of which about 200 have been reinstated.

In the meantime, the Social Security Administration has undertaken a program of reviewing cases in the larger teaching hospitals which have primarily a service clientele to determine the extent to which the payments made to the physicians (or to billing organizations on their behalf) were not in accord with the law and regulations. Large overpayments have been discovered. In each situation the Social Security Administration is discussing the matter with the appropriate individuals who will be responsible for liquidating what it believes to be a fairly large indebtedness with the objective of, first determining the overpayment and second, making arrangements for repayment. Difficulties have been encountered in recouping the large overpayments involved in these cases—typically running into hundreds of thousands of dollars.

Your committee does not question the appropriateness of fee-for-service payment for physicians' services in the typical community hospital and other teaching settings where patients are expected to pay fees for these services. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive. Also, the payments tend to support the maintenance of two classes of patients in some cases.

Therefore, the committee's bill would change the basis of reimbursement for teaching physicians' services from a fee-for-service basis to a cost-reimbursement basis where the services are furnished in a setting in which any one of the following circumstances exist: (1) the non-medicare patients are not required to pay the reasonable charges for physicians' services even when they have private insurance or are otherwise able to pay for such services; or (2) medicare patients are not required to pay any charges for physicians' services; or (3) medicare patients are required to pay reasonable charges for physicians' services but payment of deductible and coinsurance amounts applicable to such services is not generally obtained from them or on their behalf. In determining whether these requirements are met, the arrangements under which the services are provided will be taken into account. For example, if patients in wards are charged or pay less than do patients in semi-private accommodations the determination of whether

medicare will pay cost or charges might be made separately by accommodation. If the charge is different when made by a physician during hours when he is donating his time than when he is treating his own private patients, that might be a basis for establishing whether cost or charges will be paid. If charges are paid by medicare, the amount paid will have to be set so that it is reasonable for the patient-care service rendered by physicians normally billing on a fee-for-service basis. In some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. Medicare would follow the pattern of the private patient in such centers.

The Secretary would establish regulations under which the patient's ability to pay would be determined. The hospital's rules, which might be self-serving, would not be used. Your committee expects that the Secretary would test ability to pay by using the maximum income levels for a family for which Federal matching is available under the medicaid program. Under section 1903(f) of the medicaid law the maximum family income limits for Federal matching purposes are set at $1\frac{1}{3}$ times the highest amount ordinarily paid to a family without other income under the aid to families with dependent children program.

To assure equitable payment, and no loss to the hospital on services to medicare patients, where the proposed cost-reimbursement approach is applicable, your committee's bill would exempt the payments from the deductible and coinsurance provisions. Institutions ordinarily cannot collect these copay amounts from the patients in question. The elimination of the patient's liability would also substantially simplify billing.

Your committee's bill would also amend the law so that a hospital could include costs that medical schools, public health departments, and other medical service organizations incur in paying physicians to provide patient care services to medicare patients in the hospital. Your committee's bill would also permit including in a hospital's costs for purposes of part, the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered under Part A. The hospital would be required to pay to the medical school the reasonable cost of the services of such physicians.

It is anticipated that when the reimbursement for the services of teaching physicians is on the basis of 100 percent of reasonable costs (with no cost-sharing payments required from the beneficiaries), the fiscal intermediary of the particular hospital would make the required benefit-cost determinations and would initially provide the resulting reimbursement to the hospital. Such reimbursement, although a liability of the supplementary medical insurance trust fund, would be initially paid from the hospital insurance trust fund (along with the other reimbursement payments made on an interim basis by the intermediary to the hospital). From time to time throughout the year, approximate adjustments (determined by actuarial techniques) would be made on an aggregate basis between the two trust funds, such adjustments re-

flecting the amounts which the hospital insurance trust fund paid and, accordingly, should be currently reimbursed by the supplementary medical insurance trust fund (so that there is no loss of interest by the former trust fund, at the expense of the latter trust fund). Final settlements of the respective liabilities of the two trust funds (taking into account the current adjustments previously mentioned and their timing) would be made on the basis of the annual audited cost findings required in connection with hospital reimbursement.

The provisions would be effective with respect to bills submitted after the date of enactment (accounting periods after the date of enactment in the case of reasonable cost determinations).

(g) *Authority of Secretary to terminate payments to suppliers of services.*—Present law does not provide authority for the Secretary to withhold future payments for services furnished by an institutional provider of services, a physician, or any other supplier who either abuses the program or endangers the health of beneficiaries, although payment for past or current claims may be withheld on an individual basis where the services are not reasonable or necessary for treatment of illness or injury or where the supplier fails to provide the necessary payment information.

Your committee believes it important to protect the medicare, medicaid, and maternal and child health programs and their beneficiaries from those suppliers of services who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services. Such protection is not now provided under the law. For example, if a physician is found guilty of fraud in connection with the furnishing of services to a medicare beneficiary, there is no authority under present law to bar payment on his subsequent claims so long as the physician remains legally authorized to practice. States can, and some do, bar from medicaid providers who abuse the program, but they are not now required to do so.

Under your committee's bill, the Secretary would be given authority to terminate or suspend payments under the medicare program for services rendered by any supplier of health and medical services found to be guilty of program abuses. The Secretary would make the names of such persons or organizations public so that beneficiaries would be informed about which suppliers cannot participate in the program. The situations for which termination of payment could be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Also, there would be no Federal financial participation in any expenditure under the medicaid and maternal and child health programs by the State with respect to services furnished by a supplier to whom the Secretary would not make medicare payments under this provision of the bill.

Program review teams would be established in each State by the Secretary, following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers utilized in the administration of title XVIII benefits. Both the professional and the nonprofessional members of the program review teams would be responsible for reviewing and reporting on statistical data on program utilization (which the Secretary would periodically provide). In addition, the

entire program review team would review cases involving overcharging; however, only the professional members of the program review teams would review cases involving the furnishing of excessive, inferior, or harmful services in order to assure that only professionals will review other professionals under this provision.

It is not expected that any large number of suppliers of health services will be suspended from the medicare program because of abuse. However, the existence of the authority and its use in even a relatively few cases is expected to provide a substantial deterrent.

The provisions relating to title XVIII would be effective with respect to determinations made by the Secretary after enactment of the bill. The provisions relating to titles V and XIX would be effective with respect to items or services furnished after June 30, 1970.

Any person or organization dissatisfied with the Secretary's decision to terminate payments would be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

It is not intended that this provision would in any way change the Secretary's present right to withhold payment where necessary payment information is not provided. Nor would the supplier of services be entitled to a hearing or judicial review with respect to payments withheld under such existing authority.

These provisions would be effective upon enactment of the bill.

(h) *Elimination of requirement that States move toward comprehensive medicaid programs.*—Section 1903(e) of the medicaid statute requires that each State make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance." Under an amendment adopted by the Congress in 1969 (Public Law 91-36, enacted August 9, 1969), the operation of this provision was suspended for two years, until July 1, 1971, and the date by which the States were to have comprehensive medicaid programs (applying to everyone who meets their eligibility standards with respect to income and resources) was changed from 1975 to 1977.

Your committee has been concerned with the burden of the medicaid program on State finances. For example, one State recently cut back on money going to medical schools in order to finance unexpected increases in the cost of medicaid. There is evidence that States have moved more rapidly in the direction of expanding their medicaid programs, and consequently increasing their costs, because of the influence of section 1903(e).

Your committee has taken action to remove section 1903(e) from the act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of required expansion of the program could then be reconsidered.

(i) *Determination of reasonable cost of inpatient hospital services under medicaid and maternal and child health programs.*—Under present law, as defined in regulations issued by the Secretary, States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare. Several States have objected to this requirement, asserting that use of the medicare formula for medicaid reimbursement can result in

their paying more than the actual cost of providing inpatient care to those eligible for medicaid. There is nothing in the legislative history which requires that reasonable costs should be defined precisely the same way for both programs and there are reasons why they should not, such as the differing characteristics of the two populations served.

Your committee's bill retains the intent of the original provision—to avoid having hospitals or their private patients subsidize inpatient care for the poor—by providing for payment of actual and direct costs of inpatient care for medicaid eligibles. The bill would allow the States to develop their own methods and standards for reimbursement thereby giving them flexibility in working out satisfactory payment arrangements with their hospitals. The Secretary could disapprove a State's plan if it is shown to his satisfaction that the method developed by the State would not pay the actual and direct cost of providing care to medicaid eligibles. Reimbursement by the States would in no case exceed reasonable cost reimbursement as provided for under medicare.

The bill would apply the same determination of reasonable costs to maternal and child health program. The provisions would be effective July 1, 1971, or earlier if the State plan so provides.

(j) *Amount of payments where customary charges for services furnished are less than reasonable cost.*—Under present law, reimbursement under the medicare program is based on the reasonable costs incurred by providers of services (but only for inpatient hospital services under medicaid and the maternal and child health programs) in providing services to individuals covered by these programs. This results, in some cases, in these programs paying higher amounts for services received by covered individuals than such individuals would be charged if they were not covered by these programs, because, in some cases, a provider's customary charges to the general public are set at a level which does not reflect the provider's full costs.

Your committee believes that it is inequitable for the medicare, medicaid, and the child health programs to pay more for services than the provider charges to the general public. To the extent that a provider's costs are not reflected in charges to the public generally, such costs are expected to be met from income other than revenues from patient care—for example, from endowment or investment income. The bill would provide, therefore, that reimbursement for services under the medicare, medicaid, and child health programs could not exceed the lesser of the reasonable cost of such services as determined under section 1861(v) of the Social Security Act, or the customary charges to the general public for such services.

However, your committee believes that it would be undesirable to apply this provision in the case of services furnished by public providers of services free of charge or at a nominal fee. The bill would provide, therefore, that where services are furnished by a public provider of services free of charge or at a nominal charge, the Secretary shall specify by regulation reimbursement based on those elements of costs generally allowed in the determination of reasonable cost that he finds will result in fair compensation for such services. In such cases fair compensation for a service could not exceed, but could be less than, the amount that would be paid under present law.

Your committee recognizes that a provider's charges may be lower than its costs in a given period as a result of miscalculation or special circumstances of limited duration, and it is not intended that providers should be penalized by such short-range discrepancies between costs and charges. Nor does the committee want to introduce any incentive for providers to set charges for the general public at a level substantially higher than estimated costs merely to avoid being penalized by this provision. Thus, your committee recognizes the desirability of permitting a provider that was reimbursed under the medicare, medicaid and child health programs on the basis of charges in a fiscal period to carry unreimbursed allowable costs for that period forward for perhaps two succeeding fiscal periods. Should charges exceed costs in such succeeding fiscal periods, the unreimbursed allowable costs carried forward could be reimbursed to the provider along with current allowable costs up to the limit of current charges.

Your committee intends that for purposes of administering this provision, "customary charges" shall mean (1) the charges listed in an established charge schedule (if the institution has only a single set of charges applied to all patients), or (2) the most frequent or typical charges imposed (if the institution uses more than one charge for a single service). However, in order to be considered to be the "customary charge," a charge would have to be one that was actually collected from a substantial number of individuals. A charge set up in name only, perhaps primarily to avoid the effect of this provision, is not intended to determine medicare reimbursement.

The provisions relating to medicare would be effective with respect to admissions to hospitals and extended care facilities after June 30, 1970, and with respect to services furnished by home health agencies for plans initiated after June 30, 1970. Provisions relating to medicaid and maternal and child health would be effective for calendar quarters beginning after June 30, 1970.

(k) *Institutional planning under medicare program.*—Under present medicare law, there is no requirement for providers of services to develop fiscal plans such as operating and capital budgets. However, your committee is aware of the fact that health care facilities have come under increasing criticism on the grounds that they fail to follow sound business practices in their operations. The Advisory Committee on Hospital Effectiveness established by the Secretary of HEW in its report stated, "* * * the fact must be faced that deficiencies in hospital management owe something, at least to inattention, indifference, or lack of information on the part of some hospital boards, and some trustees with the best intentions and energy have not been adequately informed by administrations on what the functions of a hospital trustee, or a hospital should be." In recommending the requirement contained in the bill, the Secretary's committee stated, "The requirement that detailed budgets and operating plans be prepared annually as a condition of approval for participation in Federal programs can be expected to disclose management inefficiencies in such health care institutions as a necessary first step toward bringing about needed improvements. Especially, the committee believes this requirement will compel the attention of many hospital trustees to lapses in management that would not be permitted in their own businesses."

Under your committee's bill, providers of services (including hospitals accredited by the Joint Commission on Accreditation of Hospitals) would be required, as a condition of participation under the medicare program, to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan. The overall plan would be expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of \$100,000 for acquisition of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and the proposed methods of financing such costs. It would have to be prepared under the direction of the governing body of the institution, by a committee consisting of representatives of that body, the administrative staff and the medical staff. The plan would cover the immediately following year and the immediately following 3-year accounting period and would be reviewed and updated annually to assure that it is consistent with the budgetary program of the provider.

The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process.

The new condition of participation would have to be met with respect to any provider of services for fiscal years of the provider beginning after the fifth month after the month of enactment.

(l) *Payments to States under medicaid programs for installation and operation of claims processing and information retrieval systems.*—Under present law, States are required to use methods of administration deemed necessary by the Secretary for efficient operation of the program. Federal matching is now set at 50 percent for administrative costs and 75 percent for compensation of professional medical personnel. Despite this requirement, many States do not have effective claims administration or well-designed information storage and retrieval systems; nor do they possess the financial and technical resources to develop them if required to do so by the Secretary.

Your committee proposes to aid the States in meeting their responsibilities by authorizing 90 percent Federal matching for the cost necessary to design, develop, and install mechanized claims processing and information retrieval systems deemed necessary by the Secretary. The Federal Government acknowledges the obligation to provide technical assistance, including the development of model systems, to each State operating a medicaid program. It is expected that this financial and technical support will aid the States in realizing efficient and effective administration of the program, and that it will reduce program costs.

Your committee also recognizes the importance of this activity by providing Federal matching funds at the 75 percent rate for the operation of the system approved by the Secretary.

States would not be eligible to receive this increased Federal support until they have developed the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers, the dates on which services were furnished, and the amount of payment made. Experience with the medicare program indicates that beneficiary complaints about discrepancies between

the "explanation of benefits" form they receive, and the care actually provided, has been the largest single source of information on possible abuse and fraud. It is appropriate to combine the requirement that States provide such explanations with the increased Federal matching which would support such an activity. Savings resulting from increased administrative efficiency would more than offset the costs of this provision.

This provision of the bill would be effective July 1, 1970.

(m) *Advance approval of extended care and home health coverage under medicare program.*—Posthospital extended care benefits and posthospital home health benefits are limited to medicare beneficiaries who, while no longer in need of inpatient hospital care, still require skilled nursing care or, in the case of home health benefits, physical or speech therapy. However, extended care facilities and home health agencies often care for patients who need less skilled and less medically oriented services in addition to patients requiring the level of care which is covered by the program. Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for extended care facility or home health benefits cannot generally be made until some time after the services have been furnished. Your committee is aware that in many cases such benefits are being denied retroactively, with the harsh result that the patient is faced with a large bill he expected would be paid or the facility or agency has a patient who may not be able to pay his bill. The uncertainty about eligibility for these benefits that exists until after the care has been given tends to encourage physicians to either delay discharge from the hospital, where coverage may less likely be questioned, or to recommend a less desirable, though financially predictable, course of treatment.

Your committee believes that to the extent that valid criteria can be established posthospital extended care and home health benefits should be more positively identified by type and duration of care which would be assured of reimbursement when furnished to a beneficiary but that no change should now be made to broaden the coverage of the extended care or home health benefits with resulting increased costs. To achieve its purpose, your committee's bill provides for determining in advance a minimum period of coverage in an extended care facility or under a home health plan for patients who, considering their medical conditions, age, or other pertinent factors, can be presumed to need the type of care necessary to qualify for benefits. Under the committee bill, the Secretary would be authorized to establish, by diagnosis and length of stay or number of visits, periods for which a patient would be presumed to be eligible for benefits; the periods would be related to such factors as the period generally needed for treatment of the patient's conditions, his medical history and other health factors affecting the nature and duration of the services to be provided. Appropriate procedural requirements for demonstrating compliance with the criteria would also be established.

For example, elderly patients suffering from a fractured hip ordinarily require a period of intensive skilled nursing and rehabilitative care following the initial reduction and stabilization of the injured limb. The Secretary, drawing on program experience and other data concerning the length of such intensive care ordinarily required for

the condition, would establish a minimum period of stay in an extended care facility during which the patient would be presumed to require the skilled nursing care on a continuing basis which is reimbursable under the program. The physician would be expected to certify the type of condition and related need for extended care and submit to the facility a plan for furnishing the care prior to the patient's admission. The period of coverage established by the Secretary could take into account such factors as the length of prior hospital stay and any surgical involvement required in effecting reduction of the fracture. If the patient suffered a setback or failed to convalesce as rapidly as expected, additional extended care payments could be approved by the intermediary beyond the initial period upon submission of appropriate medical evidence. On the other hand, if the facility's utilization review committee discovered in the course of regular case review that the patient was receiving only custodial services or had recuperated sufficiently to no longer require intensive skilled care, payment during the approved period could be terminated on a prospective basis under the same procedures used when such committees determine in review of a case of extended duration, that further in-patient stay is not medically necessary.

To prevent abuse of the advance approval procedure, intermediaries and facilities would be expected to monitor, through periodic review of a sample of paid stays, utilization review committee studies, and similar measures, the reliability of individual physicians in describing the patient's condition or certifying patients' need for posthospital extended-care and home health services. The Secretary could suspend the applicability of the advance approval procedure for patients certified by physicians who are found to be unreliable. Since there will be some instances in which the patient recovers sufficiently to no longer require an extended care level of services prior to expiration of the approved stay, extended care facility utilization review committees will be expected to continue to review approved cases at appropriate intervals and, where necessary, give notice that further payment is no longer justified.

This provision would be effective January 1, 1971.

(n) *Prohibition against reassignment of claims to benefits.*—Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service. Present law also provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of HEW makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name.

Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

Your committee's bill seeks to overcome these difficulties by prohibiting payment under these programs to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. It is not the intent of your committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

Your committee's bill would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

This provision as it applies to medicare would be effective with respect to bills submitted after the enactment date. For medicaid the provision would be effective July 1, 1971, or earlier if the State plan so provides.

(o) *Utilization review requirements for hospitals and skilled nursing homes under medicaid and maternal and child health programs.*—Under present medicare law, each hospital and extended care facility is required to have a utilization review committee to review all long-stay cases as well as review, on a sample or other basis, admissions, durations of stay and professional services. The reasons for requiring hospitals and extended care facilities to have utilization review committees for medicare cases apply with equal force to review of medicaid cases, but there is now no such requirement in the medicaid law.

Your committee's proposal would require hospitals and skilled nursing homes participating in the medicaid or maternal and child health program to have cases reviewed by the same utilization review committee already reviewing medicare cases or, if one does not exist, by a committee which meets the standards established under medicare. States could, if they wish, impose more stringent requirements; e.g., they might request that the committee review medicaid patient stays earlier than medicare cases since the medicaid population is generally younger than that covered under medicare.

This provision would be effective July 1, 1971.

(p) *Elimination of requirement that cost-sharing charges imposed on individuals other than cash recipients under medicaid be related to their income.*—Under present law, a State cannot impose deductibles or other cost-sharing devices on cash assistance recipients. In addition, while deductibles or copayments can be imposed with respect to the medically indigent, they must be "reasonably related to the recipient's income and resources."

Your committee's bill would remove the restriction relating to the medically indigent in order to allow States to explore the cost advan-

tages that may result from the direct savings and possible decrease in utilization that cost-sharing devices of a specified amount for all the medically indigent might create. Even a small charge gives the recipient a sense of participation and can reduce tendency to excessive use of services. Experience with many programs covering prescription drugs has shown that a modest copayment can control excessive utilization. Your committee believes that States should have the option of introducing copayment provisions for the purpose of reducing the overutilization of services.

It would be expected that States would impose flat deductibles or copayments primarily with respect to these items of health care or services which are provided in large part at the initiative of the patient. States would be permitted to have such a copayment for such services for all of its medically indigent.

The ban on use of deductibles or copayments for cash assistance recipients would be retained.

This provision would be effective January 1, 1971, or earlier if the State plan so provides.

(q) *Notification of unnecessary admission to a hospital or extended care facility under medicare program.*—Under present law, the utilization review committee required to function in each hospital and extended care facility must review all long-stay cases and at least a sample of admissions. When in the review of a long-stay case the utilization review committee determines that further stay in the institution is not medically necessary, the committee is required to notify promptly the physician, the patient, and the institution of its finding. No medicare payment is made for any services furnished after the third day following such notification.

Your committee's bill would require a similar notification, and a similar payment cut-off after 3 days, to be made where the utilization review committee in its sample or other review of admissions finds a case where hospitalization or extended care is no longer necessary (or never was necessary). Thus, your committee's bill would remove the anomaly of continuing payment in a case where the utilization review committee determined in the course of sample or other review that admission to the institution or further stay was not necessary and would make parallel the treatment accorded long-stay cases and cases reviewed on a sample basis.

This provision would be effective with respect to services furnished after the second month following enactment of the bill.

(r) *Use of State health agency to perform certain functions under medicaid and maternal and child health programs.*—Under present law, one State agency may have the responsibility for certifying health facilities for participation in the medicare program and another agency for certifying health facilities for participation in medicaid and maternal and child health programs. Your committee believes that this duplication of effort in the establishment and maintenance of health standards is unnecessary and inefficient. Your committee's bill would require the State to provide that the State health agency shall perform these functions for medicare, medicaid, and the maternal and child health programs.

Your committee also believes that the effectiveness and economy of the medicaid program would be enhanced through development of

capability in each State to perform utilization reviews, to establish standards relating to the quality of health care furnished to medicaid recipients, and to review the quality of the services provided. Activities such as these would provide information on the under- or over-utilization of resources and the quality and appropriateness of care.

To encourage the development of the capabilities upon which these improvements would be based, the committee bill provides that Federal participation in medicaid payments be contingent upon the establishment of a plan, acceptable to the Secretary, for utilization review, the establishment of standards relating to the quality of care furnished to medicaid recipients, and review of the quality of services provided. Federal matching at the 75-percent rate is now available for the costs of the health professionals and their supporting staff found necessary in carrying out such functions.

This provision would be effective July 1, 1971.

(s) *Payments to health maintenance organizations.*—Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single capitation payment encompassing services covered under both the hospital insurance and supplementary medical insurance parts of the medicare program. Instead, medicare reimbursement to group practice prepayment plans, whether it is made on a cost or charge basis, must be related to the costs to the organization of providing specific services to beneficiaries, so that the financial incentives that such organizations have in their regular business to keep costs low and to control utilization of services do not carry over to their relationship with medicare.

Your committee believes that a serious problem in the present approach to payment for services in the health field, either by private patients, private insurance, or the Government, is that, in effect, payment is made to the provider for each individual service performed, so that other things being equal, there is an economic incentive on the part of those who make the decisions on what services are needed to provide more services, services that may not be essential, and even unnecessary services. A second major problem is that, ordinarily, the individual must largely find his own way among various types and levels of services with only partial help from a single hospital, a nursing home, a home health agency, various specialists, and so on. No one takes responsibility, in a large proportion of the cases, for determining the appropriate level of care in total and for seeing that such care, but no more, is supplied. The pattern of operation of health maintenance organizations that provide services on a per capita prepayment basis lends itself to a solution of both these problems with respect to the care of individuals enrolled with them. Because the organization receives a fixed annual payment from enrollees regardless of the volume of services rendered, there is a financial incentive to control costs and to provide only the least expensive service that is appropriate and adequate for the enrollee's needs. Moreover, such organizations take responsibility for deciding on what services the patient should receive and then seeing that those are the services he gets.

Your committee believes it would be desirable for medicare to relate itself to health maintenance organizations in a way that conforms more nearly to their usual way of doing business. The objective is to provide,

in the case of medicare beneficiaries, the same kind of financial incentives that health maintenance organizations have with respect to their other enrollees.

Accordingly, your committee's bill provides for medicare payment to such an organization with respect to beneficiaries enrolled with it to be made on a prospective per capita basis, encompassing services covered under both hospital insurance and supplementary medical insurance. (Group practice prepayment plans could, of course, choose to continue to be reimbursed under the provisions of existing law if they wished.) The payment would be determined annually in accordance with regulations of the Secretary, taking into account the organization's premiums with respect to nonmedicare enrollees (with appropriate actuarial adjustments to reflect the difference in utilization patterns between those under 65 and those over 65). This payment is to be no more than 95 percent of the estimated amount (with appropriate adjustments to assure actuarial equivalence) that would be payable if such covered medicare services were furnished outside of the framework of a health maintenance organization. Thus, the organization will be encouraged to manage its resources and provide a level of service within a predictable premium income; extensions and improvements in service could thus also be provided to beneficiaries from utilization and other savings that the organization may be able to make within resulting income. Payments to health maintenance organizations would be made from both the hospital insurance and supplementary medical insurance trust funds, with the portion from the supplementary medical insurance trust fund being the product of the total monthly premium (beneficiary and Federal Government amounts combined) times the number of medicare beneficiaries enrolled in the organization. The remainder of the payment would be made from the hospital insurance trust fund.

Under this new approach to payment of health maintenance organizations, there is expected to be a small increase in the first year or two in the amount of payment by the program. However, if additional beneficiaries enroll in either existing or newly established health maintenance organizations there is a likelihood of cost savings to the program.

The individuals with respect to whom such payment would be made are medicare beneficiaries entitled to both hospital insurance and supplementary medical insurance who are enrolled with a health maintenance organization. They would receive medicare-covered services only through the health maintenance organization, except for those emergency services as are furnished by other physicians and providers of services. The health maintenance organization would be responsible for paying the costs of such emergency services. If an enrolled individual received nonemergency care through some other means than the health maintenance organization, he would have to meet the entire expense of such care.

To qualify to receive payment in this way, a health maintenance organization would have to be one which provides: (1) either directly or through arrangements with others, health services on a prospective per capita prepayment basis; (2) all the services and benefits of both the hospital and medical insurance parts of the program; (3) physi-

cian's services, either directly by physicians who are employees or partners of the organization, or under an arrangement with an organized group of physicians under which the group is reimbursed for its services on the basis of an aggregate fixed sum or on a per capita basis. (The group of physicians which has the arrangement with the health maintenance organization could, in turn, pay its physician members on any other basis, including fee-for-service.) At least half the enrolled members of a health maintenance organization must be under age 65, and the organization would have to have an open enrollment period at least once every 2 years under which it accepts enrollees on a nondiscriminatory basis up to the limits of its capacity. The additional requirements are: (1) that the organization furnish to the Secretary proof of its financial responsibility and its capacity to provide comprehensive health services, including institutional services, effectively and economically; (2) that the organization must have arrangements for assuring that the health services required by its enrollees are received promptly and appropriately and that they measure up to quality standards. The various elements of a health maintenance organization, such as the hospital, the extended care facility or clinical laboratory, would each continue to have to meet the conditions of participation or other quality standards which apply to such organizations under present law.

If the health maintenance organization provides only the services covered by the medicare program to its enrollees, the premiums it may charge its enrollees cannot exceed the actuarial value of the cost-sharing provisions of the hospital and supplementary medical insurance parts of the medicare program. If, however, the organization provides its enrollees services in addition to those covered under medicare, it must inform enrollees of the portion of the premium applicable to such additional services, and the portion applicable to medicare-covered services may not exceed the actuarial value of the cost-sharing provisions of the medicare program. These requirements are intended to assure that beneficiaries enrolled with health maintenance organizations benefit fully from their medicare coverage and are, in effect, charged no more than the deductible and coinsurance amounts. This provision will also assure that they are made aware of the exact cost of any coverage included in the benefits provided by the health maintenance organizations which is in addition to medicare coverage.

Beneficiaries enrolled with a health maintenance organization who are dissatisfied with decisions of the organization on this benefit coverage would have the right to a hearing before the Secretary, in which the health maintenance organization would be an interested party, and to judicial review with respect to disputes involving amounts exceeding specified limits.

Beneficiaries could terminate their enrollment with a health maintenance organization and revert to regular coverage under the program in accordance with regulations. It is expected that, generally, disenrollment would take effect at the same time after the disenrollment request as is the case now with respect to disenrollment under the supplementary medical insurance program.

Your committee notes that there is sufficient authority in the present medicaid program to permit States to arrange for medicaid coverage through a health maintenance organization. It would continue to be

necessary, as required under present law, to guarantee medicaid eligibles freedom of choice of health providers. Moreover, it is expected that the Department of Health, Education, and Welfare would use the provisions of medicare law and regulations for health maintenance organizations, to the extent appropriate, in regulations dealing with similar coverage under the medicaid program.

The health maintenance organization provisions in the bill would be effective with respect to services furnished on or after January 1, 1971.

3. *Miscellaneous and technical provisions*

(a) *Coverage prior to application for medicaid.*—Under present law a State may, at its own option, cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for medicaid. Thirty-one States have elected to provide this coverage, thereby protecting persons who are eligible for medicaid but do not apply for assistance until after they have received care, either because they did not know about the medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.

Your committee believes that such coverage is reasonable and desirable and recommends that the States be required to provide protection for that 3-month period. Therefore, your committee's bill requires all States to provide coverage for care and services furnished in or after the third month prior to application for those individuals who were otherwise eligible when the services were received.

This provision would be effective July 1, 1971.

(b) *Hospital admissions for dental services under the medicare program.*—Under present medicare procedures, when a patient is hospitalized in connection with the performance of noncovered dental procedures, payment may be made for inpatient hospital services if the patient has other impairments so severe that hospitalization is necessary. In some cases, intermediaries require that a physician certify to the medical necessity of dental admissions, since hospitalization is ordinarily not necessary for the provision of dental services. Where such a certification is required, the dentist who will be performing the dental procedures must arrange for a physician to make the necessary certification.

Your committee's bill would authorize the dentist who is caring for the patient to make the determination of the necessity for inpatient hospital admission for dental services without requiring a corroborating certification by a physician. Your committee believes that in these kinds of cases the dentist is in a better position to make the necessary evaluation of the patient's condition and probable reaction to dental surgery than is a physician who may not be familiar either with the patient or the nature of the dental procedures to be performed.

This provision would be effective with respect to admissions occurring after the second month following enactment of the bill.

(c) *Exemption of Christian Science sanatoriums from certain nursing home requirements under medicaid.*—Under present law, Christian Science sanatoriums are permitted to participate in the medicaid program as skilled nursing homes, and as such, are required to meet the general requirements established for skilled nursing homes.

Your committee believes that Christian Science sanatoriums which do not actually provide medical care, should not be required to have

a skilled nursing home administrator licensed by the State, to maintain an organized nursing service under the direction of a registered nurse, to maintain detailed medical records, or to have diagnostic and other service arrangements with general hospitals. The bill would, therefore, exempt Christian Science sanatoriums from the requirements for a licensed nursing home administrator and other inappropriate requirements of the medicaid program. Such sanatoriums will be expected to continue to meet all applicable safety standards.

This provision would be effective upon enactment.

(d) *Physical therapy services under medicare.*—Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to its outpatients. The physical therapist may be either an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The limitations imposed under present law on the coverage of physical therapy have been a source of some difficulty. For example, it has been difficult to explain why physical therapy services cannot be furnished in the therapist's office, especially in cases where the latter is more accessible than the facility to which the beneficiary must travel to obtain the service.

Your committee's bill would include as covered services under the supplementary medical insurance program the services of a physical therapist in independent practice, when furnished in his office or in the patient's home (including a place of residence used as his home other than an institution which is primarily engaged in furnishing skilled health care services). These services would be furnished under such licensing and other conditions relating to health and safety as the Secretary may find necessary, such as requiring that the services be furnished pursuant to a written plan of treatment established by a physician which prescribes the amount, type, and duration of services to be furnished, and setting out professional qualifications in addition to State licensure for the physical therapists participating under this provision. The bill would provide that the Secretary establish regulations governing other conditions under which the proposed services would be furnished. Your committee expects the Secretary to be guided by the conditions now in effect for providers of outpatient physical therapy services, taking into account the less elaborate facilities generally present in the office setting, but assuring that the regulations provide for the availability of an adequate program of physical therapy services in the therapist's office.

With respect to present law as it covers physical therapy services furnished to an inpatient of a hospital or an extended care facility, there are a few cases where an inpatient exhausts his inpatient benefits and can continue to receive payment for the physical therapy treatment (as a covered expense under the supplementary medical insurance program) only if the hospital or extended care facility is able to arrange for another participating facility to furnish the physical therapy treatment as an outpatient service. Your committee's bill would author-

ize a hospital or extended care facility to furnish outpatient physical therapy services to its inpatients. This would permit an inpatient of a participating hospital or extended care facility to continue to receive covered physical therapy services under the supplementary medical insurance program in those cases where he had exhausted his inpatient benefits through which physical therapy services were covered under the hospital insurance program or where he is otherwise ineligible for hospital insurance inpatient benefits.

Your committee is concerned over the increasing costs of physical therapy services furnished in hospitals and extended care facilities. Moreover, there is considerable evidence that physical therapy has been one of the areas in the present program most subject to abuse. Accordingly, the committee bill includes two provisions for controlling program expenditures for physical therapy services and for preventing abuse:

(1) Total charges on which payment may be made in a calendar year with respect to an individual for physical therapy services furnished to him in practitioners' offices or in his home by independently practicing physical therapists may not exceed \$100 (such payment would be subject to the deductible and coinsurance provisions of the supplementary medical insurance program). Program reimbursement for the reasonable charges for the covered services would be made either to the beneficiary or, on assignment, directly to the physical therapist.

(2) With respect to physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency or by others under arrangements with such providers or other organizations, payment for the reasonable cost of such services may not exceed an amount equal to the salary which would have been payable to a qualified physical therapist if the services had been performed in an employment relationship.

The provisions for covering additional physical therapy services under supplementary medical insurance would be effective for services furnished on or after January 1, 1971. The provisions relating to physical therapy services furnished by a provider of services or other agency would be effective with respect to accounting periods beginning on or after January 1, 1971.

(e) *Extension of grace period for termination of supplementary medical insurance coverage where failure to pay premiums is due to good cause.*—Under present law, an individual's coverage under the supplementary medical insurance part of medicare is terminated for nonpayment of premiums. The termination is effective on a date determined under regulations which may be established so as to provide a grace period (not in excess of 90 days) during which overdue premiums may be paid and coverage continued.

Several types of cases have arisen in which termination of an individual's supplementary medical insurance protection for failure to pay all premiums due within 90 days is clearly inequitable. For example, there have been cases where for reasons of physical or mental incapacity the enrollee was unable to make the premium payment within the allowed time limit and there was no one acting on his behalf to protect his interests. In other cases, coverage has been terminated because the enrollee mistakenly believed that payment had been made when actually it had not.

Your committee's bill would extend the 90-day grace period for an additional 90 days where the Secretary finds that there was good cause for failure to pay the premium before the expiration of the initial 90-day grace period.

This provision would apply to such cases of nonpayment of premiums due within the 90-day period preceding the date of enactment.

(f) *Extension of time for filing claim for supplementary medical insurance benefits where delay is due to administrative error.*—Under present law, a claim for benefits under the supplementary medical insurance program must be filed by December 31 of the year following the year in which the services were provided. (For this purpose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) The present time limit is adequate for the vast majority of supplementary medical insurance claims. In some few cases, however, beneficiaries have failed to file a timely claim due to a mistake or other action on the part of the Government or one of its agents. For example, misinformation from an official source or delay in establishing supplementary medical insurance entitlement has resulted in late filing of claims.

Your committee's bill would provide that where a claim under supplementary medical insurance is not filed timely due to error of the Government or one of its agents, the claim may nevertheless be honored if filed as soon as possible after the facts in the case have been established. This provision would assure that claimants would not be treated inequitably because of such an error.

This amendment would apply with respect to bills submitted and requests for payment made after March 1968.

(g) *Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction.*—Under present law, an individual can enroll in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year), which begins within 3 years after the end of his initial enrollment period. (The committee's bill includes a provision which would eliminate the 3-year limit on enrollment. That provision is discussed immediately following discussion of this provision.)

There have been some relatively rare cases in which it has been discovered that due to an action, inaction, or error on the part of the Government an individual is in fact enrolled, or is in fact not enrolled, under supplementary medical insurance when both the individual and the Government had until then believed that the reverse was true. Such cases include instances where an individual filed an enrollment request timely 2, 3, or more years ago, but it was inadvertently misfiled and never acted upon. When the request is discovered, the individual, who did not know he had supplementary medical insurance coverage is presented with a substantial bill for premiums; or if he is a beneficiary, he may find that his benefit check is reduced or withheld altogether to pay premiums for supplementary medical insurance coverage which he never knew he had. Another type of case involves the person who enrolled in good faith and was allowed medical insurance on the basis of evidence showing that he had attained age 65; several years later new evidence is discovered which shows he was only age 64 at the time of

enrollment—that is, new evidence shows that he was not eligible to enroll when he did. In such situations the Government is forced to disallow the supplementary medical insurance coverage, refund all premiums received, recover any supplementary medical insurance benefits paid, and notify the person that if he wishes supplementary medical insurance coverage he may enroll in the next general enrollment period. Although these cases are rare, they can cause considerable hardship and distress to the individuals involved, and present law permits no relief to be given.

Your committee believes that where an individual's enrollment rights under supplementary medical insurance have been prejudiced because of the action, inaction or error on the part of the Government, he should not be penalized or caused hardship. The bill, therefore, authorizes the Secretary to provide such equitable relief as may be necessary to correct or eliminate the effects of these situations, including (but not limited to) the establishment of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums.

This provision would apply to all cases which have arisen since the beginning of the program.

(h) *Elimination of provisions preventing enrollment in supplementary medical insurance program more than 3 years after first opportunity.*—Under present law, an individual can enroll for the first time in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year) which begins within 3 years after the end of his initial enrollment period. A person whose enrollment has terminated may not enroll for the second time in supplementary medical insurance unless he does so in a general enrollment period which begins within 3 years after the effective date of such termination. An individual may reenroll only once.

The 3-year enrollment limit was included in the law (as are other limitations on enrollment in the supplementary medical insurance program) in the interest of avoiding antiselection in case the enrollment under the program was not a very substantial proportion of people eligible to enroll. For example, substantial numbers of people who are relatively healthy might delay enrollment until they are well past age 65 and have become sick, at which point they would enroll and receive substantial benefits without having paid much in premiums. However, since there is now a 95-percent rate of participation in the program and since the vast majority of enrollees enroll at the earliest possible time, there would seem to be no reason to retain the 3-year limit on enrollment. Further, present law provides that premiums for late enrollees are increased 10 percent for each full 12 months elapsed between the time they could have enrolled and actually do enroll and this provision would be retained. Such late-enrollment charges serve to prevent antiselection and to meet the higher costs associated with those who enroll at older ages.

Your committee's bill would eliminate the 3-year limit with respect to both initial enrollment and reenrollment after an initial termination. Enrollment periods would remain as presently defined and the

restriction limiting individuals who terminate enrollment to reenroll only once would be retained.

This provision would apply to all those who are ineligible to enroll under present law.

(i) *Waiver of recovery of incorrect payments from survivor who is without fault.*—Under present law, an individual to whom (or on behalf of whom) a medicare overpayment is made is subjected to recovery action with respect to such overpayment, except that the recovery action may be waived if the individual is without fault and if recovery would defeat the purposes of the cash social security title (title II) of the Social Security Act or would be against equity and good conscience. If such individual dies, recovery action is initiated as necessary any other individual who is receiving cash social security benefits on the same earnings record as the deceased overpaid beneficiary. In the latter situation, however, waiver of recovery action is not permitted even though the surviving beneficiary—a widow, for example—is without fault with respect to the overpayment.

The Social Security Amendments of 1967 included a provision which permitted recovery to be waived in the case of cash benefits if the individual from whom recovery is being considered is without fault, even though the overpaid individual was at fault. However, the comparable change with respect to medicare overpayments was not made. As a result, there are situations in which, for example, an overpayment made to a deceased beneficiary is the responsibility of his widow even though she was without fault in causing the overpayment, whereas if the overpayment had been made to or on behalf of the widow herself, the waiver provision would apply if she were not at fault.

Your committee's bill would rectify this anomaly by permitting any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purposes of title II or would be against equity and good conscience.

The provision would be effective upon enactment for overpayments outstanding at that time.

(j) *Requirement of minimum amount of claim to establish entitlement to hearing under supplementary medical insurance program.*—Under present law, people enrolled in the supplementary medical insurance program are assured an opportunity for a fair hearing by the carrier when requests for payment under supplementary medical insurance are denied or are not acted upon with reasonable promptness, or when the amount of the payment is in controversy, regardless of the dollar amount at issue. Experience under the program indicates that the holding of a full fair hearing is unwarranted in cases where the amount in controversy is relatively small. Carriers have reported cases involving \$5 and \$10 claims for which the cost of holding a fair hearing has exceeded \$100. Approximately 45 percent of the hearings held since the beginning of the program have involved an amount less than \$100. Further, regulations require carriers to have a reconsideration review of all denied claims. Such review involves different claims personnel than those who acted on the original claim and should be sufficient protection in small claims cases.

Your committee's bill would require that a minimum amount of \$100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

The provision would be effective with respect to hearings requested after the enactment of the bill.

(k) *Collection of supplementary medical insurance premiums from individuals entitled to both social security and railroad retirement benefits.*—Under present law, the responsibility for collecting supplementary medical insurance premiums for enrollees entitled to both railroad retirement benefits and social security benefits is vested in either the Social Security Administration or the Railroad Retirement Board, depending upon the circumstances of entitlement at the time of enrollment. This arrangement requires an administrative procedure under which persons so entitled can enroll in the supplementary medical insurance program with either agency. The result has been that some individuals (because all the facts are not made known at the time of enrollment) are enrolled twice and have two different identifying numbers; others are enrolled by the Social Security Administration and not enrolled by the Railroad Retirement Board, or vice versa, and thus may have two medicare cards—one showing entitlement to benefits under part A only and the other showing entitlement to benefits under both parts A and B. Such discrepancies, even though ultimately corrected, are a source of confusion to beneficiaries and a cause of unnecessary administrative expense.

Also, the processing of medical insurance claims is established so as to require that all claims submitted by or on behalf of railroad beneficiaries be handled by a single carrier, presently the Travelers Insurance Company. Because the account numbers assigned to railroad beneficiaries who enroll with the Social Security Administration are not identified as applying to railroad beneficiaries (because the beneficiary does not make this known), many railroad beneficiary claims are submitted to other carriers and require rerouting to Travelers Insurance Company. This is expensive and a cause of delay in making payments.

Your committee's bill provides that the Railroad Retirement Board shall be responsible for collection of supplementary medical insurance premiums for all enrollees who are entitled under that program. This change will eliminate the confusion, payment delay, and administrative expense deriving from the related provisions of present law.

This provision would be effective for premiums becoming due and payable after the fourth month after the month of enactment.

(l) *Payment for certain inpatient hospital services furnished outside the United States.*—Under present law, services furnished outside the United States are excluded from coverage with the single exception that hospital insurance benefits are payable for emergency inpatient services provided in nearby foreign hospitals if the beneficiary is physically present within the United States when the emergency arises and the foreign hospital to which he is admitted is closer to the place where the emergency arose or more accessible than the nearest United States hospital that is adequately equipped and available for his treatment. Your committee is concerned that under present law border residents who find that the nearest hospital suited to their inpatient care needs is located outside the United States may not receive protection against the health costs they incur in using these nearest hospitals except in the indicated emergency situations.

In connection with the Social Security Amendments of 1967, the Department of Health, Education, and Welfare and the Department of State were requested to explore the feasibility of entering into reciprocal arrangements between the United States and neighboring nations designed to make medicare benefits available to United States citizens who receive necessary hospital care in such neighboring nations. The report of the study indicated that such reciprocal arrangements are not feasible at the present time, but that unilateral extension of medicare, which could be limited to border residents, appears to be feasible.

Your committee's bill would include a provision which would expand Medicare coverage of services outside the United States to take account of the special problems of border residents. Medicare benefits would be payable, with respect to admissions after December 31, 1970, for inpatient hospital services furnished outside the United States if the beneficiary is a resident of the United States and the foreign hospital was closer to, or substantially more accessible from his residence than the nearest hospital in the United States which was suitable and available for his treatment. For such beneficiaries, benefits would be payable without regard to whether an emergency existed or where the illness or accident occurred. Only inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital approval program having essentially comparable standards would be covered.

The present provisions covering emergency inpatient hospital services outside the United States would be retained.

Payment for all covered hospital services furnished outside the United States would be made on essentially the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States. Where the hospital elected to bill the medicare program it would be reimbursed on the basis of the reasonable cost of the covered services furnished the beneficiary, as is now done with respect to emergency services furnished by a nonparticipating hospital which furnishes actual cost data. Where payment could not be made solely because the hospital did not elect to bill the program, benefits would be payable directly to the beneficiary on the basis of an itemized bill if he filed an acceptable application for reimbursement. Subject to the appropriate deductibles and coinsurance, the beneficiary would be reimbursed in an amount equal to 60 percent of the hospital's reasonable charges for "routine services" in the room occupied by him or in semi-private accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for "ancillary services," or, if separate charges for routine and ancillary services are not made by the hospital, two-thirds of the hospital's total charges.

This provision of the bill would be effective with respect to hospital admissions after December 31, 1970.

(m) *Study of chiropractic coverage.*—Your committee's bill would require the Secretary to conduct a study of chiropractic services covered under State plans approved under title XIX. The objectives of the study would be to determine whether and to what extent chiropractic services should be covered under the supplementary medical insurance program of title XVIII, giving particular attention to the limitations which should be placed on such coverage and on the amounts

to be paid for whatever services might be provided. The study would include one or more demonstration projects designed to assist in providing (under controlled conditions) the information necessary to achieve the objectives of the study. The Secretary would be required to report the results of the study to the Congress within 2 years after the date of enactment of this bill, together with his findings and recommendations based on the study, and on the information he obtains concerning the experience of public and private plans which now or did cover chiropractic services.

(n) *Extending health insurance protection to disabled beneficiaries.*—Your committee gave extensive consideration to a proposal to extend hospital insurance protection under title XVIII to disabled workers entitled to monthly cash disability benefits under the social security and railroad retirement programs. While your committee believes that extending hospital insurance protection to these beneficiaries would be most desirable, it has regretfully concluded that such an extension is not advisable at the present time.

A major factor in your committee's decision was that the per capita cost of providing hospital insurance for the disabled would be considerably higher than is the cost of providing the same coverage for the aged. The high cost (even if the proposal were limited to disabled worker beneficiaries), together with the need to bolster financing for the existing hospital insurance program for the aged (discussed elsewhere in this report), raised serious problems for which the committee found no immediately acceptable solution.

Your committee, therefore, has not included in the bill a provision to extend hospital insurance to disabled workers; rather it is directing the 1969 Advisory Council on Social Security to make a special study of the unmet need of the disabled for health insurance protection, the costs involved in providing this protection, and the ways of financing this protection. The Council would be required to include its findings in the report it will be submitting to the Secretary of Health, Education, and Welfare not later than January 1, 1971. The Council would also be required to make recommendations on the extent to which the cost of this protection could appropriately be met by the hospital insurance and supplementary medical insurance trust funds. The Council's report would be submitted to the boards of trustees of the trust funds and to the Congress.

(o) *Reimbursement of group practice prepayment plans.*—The Senate Committee on Finance in its consideration of the House enacted bill (H.R. 6675) in 1965, recommended that supplementary medical insurance enrollees who received services covered thereunder as members of group practice prepayment plans be accommodated through the recognition of program liability on a cost basis for such services at the election of such a plan. This committee concurred in the recommendation.

It was the understanding of the Congress that the cost reimbursement of group practice prepayment plans would take into consideration the cost of the services made available to the members of such group practice plans who are medicare enrollees, to the end that costs with respect to medicare enrollees would not be borne by other members of the plan, and that the costs with respect to such other members would not be borne by the supplementary medical insurance program.

Thus, it was anticipated that the total allowable remuneration to plan physicians by the group practice plan would be allocated proportionately as between medicare members and other members of the plan with due recognition being given to time and utilization factors appropriate to the respective groups. To the extent that existing administrative procedures for reimbursing group practice plans on a cost basis are at variance with these principles or limit the right of such a plan to elect to be reimbursed on the basis of allocated costs, such procedures do not conform to the legislative intention with regard to the reimbursement for the services furnished by such plan.

(p) *Accelerated depreciation as part of cost reimbursement under medicare and medicaid in certain limited circumstances.*—The cost reimbursement provisions of the medicare and medicaid law do not specify whether accelerated depreciation should be allowed in computing the costs of a participating institution. When the original reimbursement regulations were developed, they specified that the then existing provisions for accelerated depreciation in the Federal income tax law that allowed the use of the sum of the years digits and double declining balance approaches could also be employed in medicare. Since that time, the income tax provisions have been modified. Also, difficulties have arisen under medicare in connection with the payment of accelerated depreciation during the early years of the life of an asset, particularly where the asset was sold by the original provider institution. In such cases, difficulty in recouping the additional medicare payments that had been allowed through the use of accelerated depreciation has been encountered.

In recognition of these developments, the Department has published a proposed regulation deleting the allowance of accelerated depreciation on assets that are acquired in the future. Hospitals and other institutional providers have expressed concern to your committee about hardships these proposed regulations would cause, and have noted that (1) a number of these institutions had made valid construction, acquisition, or permanent financial commitments before publication of the proposed regulations in connection with which they had assumed the availability of accelerated depreciation in accordance with existing regulations, and (2) there is an increasing necessity for health care institutions to finance capital additions and expansions of service through the use of mortgage loans under which, in the absence of accelerated depreciation allowances, they cannot meet the principal amortization schedules they have to pay on capital debts they incur.

With regard to the first problem, it seems reasonable to your committee to continue the application of the original regulations allowing accelerated depreciation on capital assets of participating providers where the financial commitment involved was entered into prior to February 5, 1970, and your committee has obtained the agreement of the Department of Health, Education, and Welfare to do so. February 5, 1970, is the date of the publication of the proposed regulations, so commitments could not have been entered into with knowledge of your committee's agreement with the Department.

Second, because health care institutions are undoubtedly required in many instances to rely on capital borrowing, your committee also recommends that, in the case of financial commitments entered into on or after February 5, 1970, the regulations allow 150 percent declining

balance depreciation to be paid on assets acquired in the future where the cash flow from depreciation on the total assets of the institution, including straight-line depreciation on the assets in question, is insufficient to supply the funds required to meet reasonable principal amortization schedules on the capital debts related to the provider's depreciable assets. Under this recommendation, the allowance of accelerated depreciation payments would be directly tied to the institution's problem of capital debt retirement. For the future, the allowance would be available only in those cases in which a demonstrable need exists. Further, the type of accelerated payment (150-percent declining balance) would be generally consistent with the formula that continues to be allowed in certain cases under the Federal income tax law.

(g) *Equivalency testing for personnel of independent clinical laboratories.*—In order to assure the accuracy and reliability of laboratory test results, present law requires the Secretary to establish health and safety criteria as conditions for medicare coverage of services furnished by independent laboratories. Among the standards found to be necessary safeguards by the Department of Health, Education, and Welfare were criteria for judging professional competency and qualifications of laboratory personnel. Since membership in or certification by professional organizations has long been one of the principal means of establishing professional qualifications in health fields, this approach was the one primarily relied on by the Secretary in developing medicare regulations. Medicare regulations also provide that individuals meeting certain formal and highly specialized educational and experience requirements may be found to qualify.

While your committee agrees that many of the present requirements for laboratory personnel have merit, it has concluded that the heavy reliance placed on private professional organizations has served to prevent experienced people either from entering the clinical laboratory field altogether or from making this their career—moving from a lower skilled job to a higher skilled one. What makes this such a critical problem is that laboratories are currently experiencing a sharp expansion in the demand for their services. As the services of laboratories have increased in scope and complexity, they have been faced with an ever-widening gap between their manpower requirements and the available supply of laboratory technologists and technicians.

Your committee believes that both recruitment and utilization of laboratory personnel would be greatly enhanced by the use of equivalency and proficiency examinations. The use of such examinations would greatly increase career mobility in the laboratory field, thereby making the profession more attractive generally, facilitating the recruitment and retention of laboratory workers, and encouraging re-entry into the field by those who have left it. There is increased interest in and receptivity to the idea of equivalency testing among the professions—an interest recently emphasized in a report issued in March 1970 on "Equivalency and Proficiency Testing" by the National Committee for Careers in Medical Technology.

Your committee is aware that many ex-servicemen have received valuable training in the armed forces clinical laboratories. The change to proficiency and equivalency testing should provide assurances that many such individuals will be able to make their specialized training available in civilian clinical laboratories.

Your committee has received the assurances of the Department of Health, Education, and Welfare that it will immediately begin consultation with appropriate professional health organizations and educational institutions to develop proficiency testing and educational equivalency mechanisms for use in determining the qualifications of laboratory personnel under the medicare program.

The Department has been requested and has agreed to furnish a report to the Congress on or before July 1, 1971, indicating the progress it has made in carrying out such assurances.

(r) *Optometrists' services.*—Your committee believes that the medicare provisions as related to optometrists may need revision in that some optometric services when provided by a physician are covered, but may not be covered when provided by an optometrist. The Department of Health, Education, and Welfare should conduct a study of this problem and submit language to your committee designed to remove any existing inequity.

(s) *Homemakers' services under medicare.*—Your committee gave consideration to coverage of the services of home maintenance workers (homemakers) as part of home health services under both the hospital and medical insurance programs. Under present law, the home health benefit is designed for those beneficiaries whose conditions do not require the continuous medical and paramedical care provided in hospitals and extended care facilities, but nevertheless, are of such severity that the individuals are under the care of a physician, confined to their homes, and in need of active health care requiring skilled services. Care that is primarily custodial in nature, whether the care is provided in a nursing home or provided by a health aide in a private home, is not covered under the medicare program. Nor is the care covered when the patient needs only personal care or nonskilled health care.

Although home maintenance services as such are not covered under the home health benefit the covered services of a home health aide may include certain home maintenance services which are performed by the aide under professional supervision. These services may include keeping a safe environment in areas of the home used by the patient, such as changing the bed, light cleaning, laundering essential to the comfort and cleanliness of the patient and include seeing to it that the patient's nutritional needs are met, which may include purchase of food and assistance in preparation of meals. These services may be covered when they are only incidentally provided while the home health aide is fulfilling her primary function of providing health services.

Your committee believes that while financial assistance in maintaining one's home may be necessary and desirable for the well-being of an older person, it is not the purpose of the medicare program to cover all services an older person may need or use, particularly those which are not clearly a part of the person's health care. In view of these priorities, your committee is requesting the 1969 Advisory Council on Social Security to make a study of the unmet need of medicare beneficiaries for homemaker services.

C. STUDY OF THE SOCIAL SECURITY PROGRAM BY THE ADVISORY COUNCIL ON SOCIAL SECURITY

An Advisory Council on Social Security, authorized by the Congress in the Social Security Act and appointed under the provisions of the

Act by the Secretary of Health, Education, and Welfare, is currently conducting an overall review of the social security program. The Council is required by law to review all aspects of the social security program, including specifically the status of the social security trust funds in relation to the long-term commitments of the social security program, the scope of coverage and the adequacy of benefits under the program, and its impact on public assistance programs under the act. Under the law the Council is to report its findings and recommendations to the Secretary of Health, Education, and Welfare by January 1, 1971, who thereupon is to transmit the report to the Congress and to the boards of trustees of the social security trust funds.

In its deliberations your committee took note of the current study being made by the Advisory Council on Social Security. It is the view of your committee that it would be advisable to have the benefit of the study, findings, and recommendations of the Advisory Council before considering further two proposals for changes in the social security program: (1) extending the protection of the medicare program to disabled social security beneficiaries (discussed earlier in more detail on page 63) and (2) the computation of a married couple's social security benefits when both the husband and the wife have worked. Your committee is particularly interested in having the Advisory Council explore the difficult obstacles that must be overcome in order to achieve satisfactory results with respect to both of these issues. Your committee, therefore, requests the Council to include in its report specific recommendations on how the coverage of the medicare program may be extended to social security disability beneficiaries and how the benefits paid to a married couple may be equitably based on their combined earnings.

In addition, your committee requests the Council to make a special study of the unmet need of medicare beneficiaries for homemaker services, beyond those already provided to persons in need of skilled health services. The Council should include its findings in the report it will be submitting to the Secretary of Health, Education, and Welfare not later than January 1, 1971. The Council should also make recommendations on the extent to which the cost of this protection if deemed appropriate and necessary could be met by the hospital insurance and supplementary medical insurance trust funds.

D. FINANCING

Financing provisions

Consistent with the policy of maintaining the social security program on a financially sound basis, which has been followed in the past, the bill would make provision for meeting the cost of the expanded program. At the present time, the social security cash benefits program is in close actuarial balance, while the hospital insurance program has an actuarial deficiency; that is, it is expected that over the long-range future the income to the hospital insurance program will be considerably less than the costs of the program. To meet the cost of the expanded cash benefits program and to bring the hospital insurance program into actuarial balance, the schedule of contribution rates would be revised and the contribution and benefit base—the maximum amount of annual earnings subject to contributions and used in computing benefits—would be increased.

(a) *Increase in the contribution and benefit base.*—The proposed increase in the contribution and benefit base from \$7,800 to \$9,000 would not only provide higher future benefits at higher earnings levels, but would also help to finance the changes made by the bill. An increase in the base results in a reduction in the overall cost of the social security program as a percent of taxable payroll. This occurs because the benefits provided are a higher percentage of earnings at the lower levels than at the higher levels, while the contribution rate is a flat percentage of earnings. When the base is increased, higher benefits are provided on the basis of the higher earnings that are taxed and credited, but the cost of providing these higher benefits is less than the additional income from the combined employee and employer contributions on earnings above the former maximum and up to the new maximum amount.

(b) *Changes in the contribution rates.*—Under the schedule of contribution rates for cash benefits that your committee recommends (shown below), the contribution rate scheduled for 1971–72 would be decreased from 4.6 percent each for employees and employers to 4.2 percent each. The rate scheduled for 1973–74 under present law would be decreased from 5 percent each to 4.2 percent each. The rate scheduled for 1975–79 would be 5.0 percent, the same as under present law. After 1979, the contribution rate would be 5.5 percent each, instead of 5 percent as under present law.

For the self-employed, the rate scheduled for 1971–72 for the cash benefits part of the program would be decreased from 6.9 percent to 6.3 percent. The rate scheduled for 1973–74 would be decreased from 7 percent to 6.3 percent. Thus the currently payable rate of 6.3 percent would remain in effect until 1975, at which time the increase to 7 percent, the highest rate scheduled under present law, would go into effect.

Your committee also recommends changes in the contribution rate schedule for the hospital insurance program. The contribution rate would be increased from 0.6 percent each for employees, employers, and the self-employed to 1 percent each beginning in 1971. The rate would be kept at 1 percent thereafter. Under present law the rate is scheduled to increase gradually from the present 0.6 percent to 0.9 percent for 1987 and after.

CONTRIBUTION RATE SCHEDULES UNDER PRESENT LAW AND H.R. 17550

[In percent]

Period	OASDI		HI		Total	
	Present law	H.R. 17550	Present law	H.R. 17550	Present law	H.R. 17550
Employer-employee, each:						
1970.....	4.2	4.2	0.6	0.6	4.8	4.8
1971–72.....	4.6	4.2	.6	1.0	5.2	5.2
1973–74.....	5.0	4.2	.65	1.0	5.65	5.2
1975.....	5.0	5.0	.65	1.0	5.65	6.0
1976–79.....	5.0	5.0	.7	1.0	5.7	6.0
1980–86.....	5.0	5.5	.8	1.0	5.8	6.5
1987 and after.....	5.0	5.5	.9	1.0	5.9	6.5
Self-employed:						
1970.....	6.3	6.3	0.6	0.6	6.9	6.0
1971–72.....	6.9	6.3	.6	1.0	7.5	7.3
1973–74.....	7.0	6.3	.65	1.0	7.65	7.3
1975.....	7.0	7.0	.65	1.0	7.65	8.0
1976–79.....	7.0	7.0	.7	1.0	7.7	8.0
1980–86.....	7.0	7.0	.8	1.0	7.8	8.0
1987 and after.....	7.0	7.0	.9	1.0	7.9	8.0

(c) *Change in allocation to the disability insurance trust fund.*—The bill would revise the allocation of contribution income to the disability insurance trust fund without significantly altering the long-range income of the fund. Under present law, 1.10 percent of taxable wages and 0.825 of 1 percent of self-employment income are allocated to the disability insurance trust fund. Under the committee's bill, the allocation to the disability insurance trust fund would be as follows:

[In percent]

Calendar year	Taxable wages	Self-employment income
1971-74.....	0.90	0.6750
1975-79.....	1.05	.7875
1980 and after.....	1.15	.8625

The revision in the allocation is necessary because, under present law, the size of the disability insurance trust fund is expected to grow rapidly over the next several years. Your committee believes that this growth is not necessary nor wise and that the allocation rate may be safely reduced below that specified in present law until 1980.

(d) *Effective date of increase in the contribution and benefit base for self-employed persons reporting on a fiscal year basis.*—In the past when increases in the contribution and benefit base have been enacted they have been effective, for self-employed people who report their income on a fiscal year basis, (i) with respect to contributions, for fiscal years ending in the calendar year in which the increase in the base became effective, and (ii) with respect to crediting for benefit purposes, at the beginning of the calendar year in which the increase in the base became effective. As a result, certain self-employed people were required to pay social security contributions on income that could not be credited for benefit purposes. For example, the last increase in the base, to \$7,800, was effective for the calendar year 1968; for self-employed persons reporting their income on a fiscal year basis the increase was effective (i) with respect to contributions, for fiscal years ending in 1968, and (ii) with respect to crediting for benefit purposes, at the beginning of 1968. A fiscal year taxpayer whose fiscal year ended on June 30, 1968, for example, and who had self-employment income of \$7,800 for that year would have had to pay contributions on the full \$7,800 but could have had only \$7,200 counted toward benefits (\$3,300—one-half of the \$6,600 base amount that was in effect in 1967—for the period July 1 through December 31, 1967, plus \$3,900—one-half of the \$7,800 base amount that was in effect in 1968—for the period January 1 through June 30, 1968).

Your committee believes that a taxpayer should not have to pay social security contributions on income that he cannot have credited for social security benefits. Accordingly, your committee's bill would provide that, for self-employed persons who report their income on a fiscal year basis, the increase in the base from \$7,800 to \$9,000 that would occur under the bill would be effective for contribution purposes for fiscal years beginning in 1971, the calendar year in which the increase in the base is effective, rather than for fiscal years ending in 1971, as would be the case if past practice were followed. Under this change no fiscal year taxpayer would have to pay social security contributions on income that he could not have credited for social security

benefits. On the other hand, he could not start having more than \$7,800 a year counted toward his benefits until his fiscal year begins sometime after January 1, 1971, the date on which the increase in the base to \$9,000 becomes effective generally.

IV. ACTUARIAL COST ESTIMATES UNDER THE BILL

A. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The old-age, survivors, and disability insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by your committee's bill shows an actuarial balance of -0.12 percent of taxable payroll under the intermediate-cost estimate. This is, of course, close to an exact balance, especially considering that a range of variation is necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by your committee's bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows exact actuarial balance under the provisions that would be in effect after enactment of your committee's bill, because the contribution rates allocated to this fund are exactly the same as the cost of the disability benefits, based on the intermediate-cost estimate. Accordingly, the disability insurance program, as it would be modified by your committee's bill, is actuarially sound.

(b) *Financing policy*

(1) *Contribution rate schedule for old-age, survivors, and disability insurance in H.R. 17550*

The contribution schedule for old-age, survivors, and disability insurance contained in your committee's bill, as to the combined employer-employee rate, is lower than that under present law by 0.8 percent in 1971-72, and by 1.6 percent in 1973-74, is the same in 1975-79, and is 1.0 percent higher in 1980 and after. The maximum earnings base to which these tax rates are applied is \$9,000 per year for 1971 and after under your committee's bill as compared with \$7,800 under present law. These tax schedules are as follows:

Calendar year	[Percent]			
	Combined employer-employee rate		Self-employed rate	
	Present law	H.R. 17550	Present law	H.R. 17550
1970.....	8.4	8.4	6.3	6.3
1971-72.....	9.2	8.4	6.9	6.3
1973-74.....	10.0	8.4	7.0	6.3
1975-79.....	10.0	10.0	7.0	7.0
1980 and after.....	10.0	11.0	7.0	7.0

The allocated rates to the two trust funds that are applicable to the combined employer-employee contribution rate for your committee's bill, as compared with present law, are as follows:

Calendar year	[Percent]			
	Old-age and survivors insurance		Disability insurance	
	Present law	H.R. 17550	Present law	H.R. 17550
1970.....	7.3	7.30	1.1	1.10
1971-72.....	8.1	7.50	1.1	.90
1973-74.....	8.9	7.50	1.1	.90
1975-79.....	8.9	8.95	1.1	1.05
1980 and after.....	8.9	9.85	1.1	1.15

The corresponding allocated rates for the self-employed contribution rate are as follows:

Calendar year	[Percent]			
	Old-age and survivors insurance		Disability insurance	
	Present law	H.R. 17550	Present law	H.R. 17550
1970.....	5.475	5.4750	0.825	0.8250
1971-72.....	6.075	5.6250	.825	.6750
1973-74.....	6.175	5.6250	.825	.6750
1975-79.....	6.175	6.2125	.825	.7875
1980 and after.....	6.175	6.1375	.825	.8625

It should be remembered that the workers and employers contribute a combined, rounded rate for the two programs (old-age and survivors insurance and disability insurance), and not the above complex fractional rates separately. Such fractional rates are merely used by the Treasury Department to divide up the aggregate tax receipts between the two trust funds.

The schedule of allocation rates for the disability insurance trust fund in your committee's bill has been obtained in the following manner. For the combined employer-employee tax, the total rate for both old-age and survivors insurance and disability insurance was multiplied by the ratio of the level-cost of the disability insurance program (1.10 percent of taxable payroll) to the level-cost for both programs combined (10.51 percent of taxable payroll), and the result rounded to the nearest 0.05 percent. The allocation rate for the self-employed tax for disability insurance was then computed at 75 percent of the allocation rate for the combined employer-employee tax.

The allocation rates for the old-age and survivors insurance trust fund were obtained by merely subtracting the allocation rates for the disability insurance trust fund from the appropriate total tax rates.

(2) *Self-supporting nature of system*

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should

be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and thus actuarially sound.

(3) *Actuarial soundness of system*

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is frequently not the case for well-administered private pension plans, which may not, as of the present time, have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs over the long-range period considered in the actuarial valuation. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group during the period considered in the valuation. The additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long-range period considered in the valuation, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

Your committee believes that it is a matter for concern if the old-age survivors, and disability insurance system shows any significant actuarial insufficiency. Traditionally, since 1965 (when the cost estimates were first made on a 75-year basis), the view has been held that, if such

actuarial insufficiency has been no greater than 0.10 percent of payroll, it is at the point where it is within the limits of permissible variation.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in your committee's bill are in close conformity with these financing principles.

(c) Basic assumptions for cost estimates

(1) General basis for long-range cost estimates

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1980 and after) have usually been presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. It has not been possible, in the time available, to prepare such range estimates, but rather only an intermediate-cost estimate, which is used to indicate the basis for the financing provisions. This estimate is based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1970. The use of 1970 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently in item 5). In 1971, the aggregate amount of earnings taxable under the program with the proposed \$9,000 earnings base is estimated at \$469 billion. Of course, for future years the total taxable earnings are estimated to increase, because there will be larger numbers of covered workers.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with both prior and subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2015, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

(2) Measurement of costs in relation to taxable payroll

In general, the costs are shown as percentages of taxable payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to a greater extent, its income. The result is that the cost relative to

payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of \$400 per month. Under your committee's bill such an individual would have a primary insurance amount of \$185.60. If his earnings rate should be 50 percent higher (i.e. \$600), his primary insurance amount would be \$246.40. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 33 percent. Or to put it another way, when his earnings rate was \$400 per month, his primary insurance amount represented 46.4 percent of his earnings, whereas, when his earnings increased to \$600 per month, his primary insurance amount relative to his earnings decreased to 41.1 percent.

(3) *General basis for short-range cost estimates*

The short-range cost estimates (shown for the individual years 1970-75) are not presented on a range basis since—assuming a continuation of present economic conditions—it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future (about 4-5 percent per year), somewhat below that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

The cost estimates have, in general, been prepared on the basis of the same assumptions and methodology as those contained in the 1970 Annual Report of the Board of Trustees (H. Doc. No. 91-295).

(4) *Level-cost concept*

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the trust funds would result, and in consequence there would be a sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

(5) *Future earnings assumptions*

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings levels of covered workers by age and sex will continue over the next 75 years at the levels estimated to be experienced in 1970. This does not mean covered payrolls are assumed to be the same each year; rather, they will rise steadily as the covered population at the working ages is estimated to increase. If in the future the earnings level should be considerably above that which now prevails, and if the benefits are adjusted upward so that the annual costs relative to payroll will remain the same as now estimated for the present system, then the increased dollar outgo resulting will offset the increased dollar income.

This is an important reason for considering costs relative to payroll rather than in dollars.

It should be noted that estimated 1970 earnings levels are used in the long-range cost estimates, even though the experience for the year is not yet completed. It is believed that this is appropriate procedure (under the accompanying assumption that the earnings base will be increased at times in the future to keep up to date with increases in the general level of earnings) for evaluating the costs of proposed benefit increases which will become effective after the current year.

The long-range cost estimates have not taken into account the possibility of a rise in earnings levels, although such a rise has characterized the past history of this country. If such an assumption were used in the cost estimates, along with the unlikely assumption that the benefits, nevertheless, would not be changed, the cost relative to payroll would, of course, be lower.

It is important to note that the possibility that a rise in earnings levels will produce lower costs of the old-age, survivors, and disability insurance program in relation to payroll is a very important safety factor in the financial operations of this system. The financing of the system is based essentially on the intermediate-cost estimate, along with the assumption of level earnings; if experience follows high-cost assumptions, additional financing will be necessary. However, if covered earnings increase in the future as in the past, the resulting reduction in the cost of the program (expressed as a percentage of taxable payroll) will more than offset the higher cost arising under experience following a high-cost estimate. If the latter condition prevails, the reduction in the relative cost of the program coming from rising earnings levels can be used to maintain the actuarial soundness of the system, and any remaining savings can be used to adjust benefits upward (to a lesser degree than the increase in the earnings level). However, the possibility of future increases in earnings levels should be considered only as a safety factor and not as a justification for adjusting benefits upward in anticipation of such increases.

If benefits are adjusted currently to keep pace fully with rising earnings as they occur, the year-by-year costs as a percentage of payroll would be unaffected. If benefits are increased in this manner, the level-cost of the program would be higher than now estimated, since under such circumstances, the relative importance of the interest receipts of the trust funds would gradually diminish with the passage of time. If earnings and benefit levels do consistently rise, thorough consideration will need to be given to the financing basis of the system because then the interest receipts of the trust funds will not meet as large a proportion of the benefit costs as would be anticipated if the earnings level had not risen.

(6) Interrelationship with railroad retirement system

An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service and also for all survivor cases.

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust

fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that, over the long range, the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings.

(7) *Reimbursement for costs of pre-1957 military service wage credits*

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. These financing provisions were modified by the 1965 amendments. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of the law. These reimbursements are intended to be made on the basis of a constant annual amount (as determined by the Secretary of Health, Education, and Welfare) for each trust fund payable over the period up to the year 2015 (with such amount subject to adjustment every 5 years).

In actual practice, the Secretary of Health, Education, and Welfare determined initially that the annual amount for the three trust funds involved (old-age and survivors insurance, disability insurance, and hospital insurance) was \$120 million. However, the Budget Document of the United States has contained requests for appropriations for only \$105 million and, to date, the appropriations have been made by the Congress on that basis.

(8) *Reimbursement for costs of additional post-1956 military service wage credits*

Under your committee's bill, individuals in active military service during 1957-67 will receive additional wage credits in excess of their cash pay (but within the maximum creditable earnings base) in recognition of their remuneration that is payable in kind (e.g., quarters and meals). These additional credits are at the rate of \$100 per month. (Such credits for military service after 1967 is provided in present law—as a result of the 1967 amendments.) The additional costs that arise from these credits are to be financed from general revenues on an "actual disbursements cost" basis, with reimbursement to the trust funds on as prompt a basis as possible (and with interest adjustments to make up for any delay due to the time needed to make the necessary actuarial calculations from sample data and for the necessary appropriations to be made).

In many instances, the availability of these additional wage credits will not result in additional benefits because the individual will have maximum credited earnings without them or because the year in which such credits are granted will be a drop-out year in the computation of his average monthly wage. In the immediate-future years, the cost of these additional credits to the general fund will be relatively small (only about \$35 million a year) since there will be relatively few cases arising, almost all due to death and disability.

(d) *Actuarial balance of program in past years*

(1) *Actuarial balance of program after enactment of 1967 act*¹

The changes made by the 1967 amendments involved an increased cost that was fully met by the accompanying changes in the financing provisions (namely, an increase in the contribution rates in 1973 and after and an increase in the earnings base). After an increase in the allocation to the disability insurance system, both that portion of the program and the old-age and survivors insurance portion were estimated to be in close actuarial balance.

In 1968 the cost estimates were completely revised, based on the availability of new operating data. The new estimates showed significantly lower costs. The actuarial balance of the old-age, survivors, and disability insurance program increased from +0.01 percent of taxable payroll to +0.53 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1968 earnings assumption (instead of 1966 earnings) +0.33 percent; (2) use of 4¼ percent interest assumption (instead of 3¾ percent), +0.11 percent; (3) use of higher female labor force participation rates, +0.06 percent; and (4) other factors, +0.02 percent.

Then, in 1969, another complete revision of the actuarial cost estimates was made. The estimated cost of the program was again significantly reduced. The actuarial balance of the old-age survivors, and disability insurance program was thereby increased from the figure of +0.53 percent of taxable payroll according to the 1968 estimate to +1.16 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1969 earnings assumption (instead of 1968 earnings), +0.22 percent; (2) use of 4¾-percent interest assumption (instead of 4¼ percent), +0.11 percent; (3) use of higher labor force participation rates, for both men and women, +0.23 percent; and (4) other factors, +0.07 percent.

(2) *Actuarial balance of program after enactment of 1969 act*

According to the cost estimates for the 1967 act made in 1969, there was a very favorable actuarial balance for the combined old-age survivors, and disability insurance system, but that there was a deficit of 0.01 percent of taxable payroll for the disability insurance portion, and a favorable balance of 1.17 percent of taxable payroll for the old-age and survivors insurance portion.

Under the 1969 act, the benefit changes made were financed by utilizing the existing favorable actuarial balance, without any increases in the contribution rates and the earnings base. Accordingly, since the disability insurance system was in such close actuarial balance under the then-existing law, it was necessary to increase the portion of the combined contributions which were allocated to it, so as to finance the cost of the 15-percent benefit increase. Under the new allocation basis, both the old-age and survivors insurance system and the disability insurance system were in close actuarial balance.

(3) *Actuarial balance of program under H.R. 17550*

Table I traces through the change in the actuarial balance of the system from its situation under present law, according to the latest estimate, to that under your committee's bill, by type of major changes involved, determined as of January 1, 1970.

¹ For details of the actuarial balance of the program before the enactment of the 1967 act, see page 83, H. Rept. 544, 90th Cong.

TABLE 1.—CHANGES IN ACTUARIAL BALANCE OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, BY TYPE OF CHANGE, INTERMEDIATE-COST ESTIMATE, PRESENT LAW AND H.R. 17550

[Percent]			
Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system	-0.08	0.00	-0.08
Effect of using 1970 earnings	+ .25	+ .03	+ .28
Increase in earnings base	+ .20	+ .03	+ .23
Age-62 computation point for men	- .12	(1)	- .12
Earnings test changes	- .10	(1)	- .10
Widow's benefits of 100 percent of PIA at 65	- .24	(2)	- .24
Elimination of actuarial reduction when shifting from one benefit to another	- .10	(1)	- .10
Miscellaneous changes ³	- .01	- .01	- .02
Benefit increase of 5 percent	- .43	- .05	- .48
Revised contribution schedule	+ .51	.00	+ .51
Total effect of changes in bill	- .04	.00	- .04
Actuarial balance under bill	- .12	.00	- .12

¹ Less than 0.005 percent.

² Not applicable to this program.

³ Includes the following: child's benefits for children disabled at ages 18 to 21; workmen's compensation offset based on 100 percent of "average current earnings" as maximum; elimination of support requirement for divorced wife's and widow's benefits; reduced widower's benefits at age 60, and liberalization of insured status requirements for disability benefits with respect to blind persons.

The changes made by your committee's bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance system. The estimated actuarial balance of -0.12 percent of taxable payroll is not quite inside the established limit within which the system is considered substantially in actuarial balance (i.e. -0.10 percent of taxable payroll), but your committee believes that this small difference will readily be made up when the actuarial valuation is made in the latter part of 1971, when data on 1971 earnings become available.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(e) *Level-costs of benefit payments, by type*

The level-cost of the old-age and survivors insurance benefit payments (without considering administrative expenses, the railroad retirement financial interchange, and the effect of interest earnings on the existing trust fund) under the 1969 act, according to the latest intermediate-cost estimate, is 8.90 percent of taxable payroll, and the corresponding figure for the program as it would be modified by your committee's bill is 9.43 percent. The corresponding figures for the disability benefits are 1.10 percent for the 1969 act and also 1.10 percent for your committee's bill.

Table II presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of your committee's bill, separately for each of the various types of benefits.

TABLE II.—ESTIMATED LEVEL-COST OF BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, AFTER ENACTMENT OF COMMITTEE BILL, AS PERCENTAGE OF TAXABLE PAYROLL,¹ BY TYPE OF BENEFIT, INTERMEDIATE-COST ESTIMATE

[Percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits.....	6.45	0.90
Wife's and husband's benefits.....	.50	.06
Widow's and widower's benefits.....	1.54	(2)
Parent's benefits.....	.01	(2)
Child's benefits.....	.73	.14
Mother's benefits.....	.13	(2)
Lump-sum death payments.....	.07	(2)
Total benefits.....	9.43	1.10
Administrative expenses.....	.13	.04
Railroad retirement financial interchange.....	.09	.00
Interest on existing trust fund ³	-.24	-.04
Net total level-cost.....	9.41	1.10

¹ Including adjustment to reflect the lower contribution rate on self-employment income and on tips, as compared with the combined employer-employee rate.

² This type of benefit is not payable under this program.

³ This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

(f) *Income and outgo in near future*

Under your committee's bill, benefit disbursements under the old-age, survivors, and disability insurance system will increase, over present law, by about \$3.9 billion for the first full year of operation of these changes.

The contribution income for the old-age, survivors, and disability system for 1971 is about \$1.3 billion lower under your committee's bill than under present law (as a result of the tax rate under the bill being lower than under present law—which more than offsets the effect of the higher maximum taxable earnings base). However, when the contribution income for the old-age, survivors, and disability insurance system and the hospital insurance system are considered in combination, the contribution income for 1971 is \$2.7 billion more under your committee's bill than under present law (due to the effect of the higher earnings base, since the combined employer-employee contribution rate for the two programs considered in combination is unchanged—although the self-employed contribution rate for the two programs combined is slightly lower).

Under the program as modified by your committee's bill, according to this estimate, the old-age and survivor's trust fund will increase slowly during 1970–74, rising from \$32.1 billion at the end of 1970 to \$38.3 billion at the end of 1974, or at a rate of \$1–2 billion per year. Then, in 1975, when the contribution rates increase sharply (the combined employer-employee rate going from 8.4 percent to 10.0 percent), the trust fund increases by \$10.4 billion; such large increases will also occur in the years immediately following 1975. The trust fund balance at the end of the year during the period 1970–74 closely approximates

1 year's outgo for benefit payments. Table III presents these short-range estimates.

TABLE III.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE
[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange ²	Interest on fund ¹	Balance in fund at end of year ³
Actual data:						
1951	\$3,367	\$1,885	\$81	-----	\$417	\$15,540
1952	3,819	2,194	88	-----	365	17,442
1953	3,945	3,006	88	-----	414	18,707
1954	5,163	3,670	92	—\$21	447	20,576
1955	5,713	4,968	119	—7	454	21,663
1956	6,172	5,715	132	—5	526	22,519
1957	6,825	7,347	162	—2	556	22,393
1958	7,566	8,327	194	124	552	21,864
1959	8,052	9,842	184	282	532	20,141
1960	10,866	10,677	203	318	516	20,324
1961	11,285	11,862	239	332	548	19,725
1962	12,059	13,356	256	361	526	18,337
1963	14,541	14,217	281	423	521	18,480
1964	15,689	14,914	296	403	569	19,125
1965	16,017	16,737	328	436	593	18,235
1966	20,658	18,267	256	444	644	20,570
1967	23,216	19,468	406	508	818	24,222
1968	24,101	22,643	476	438	939	25,704
1969	28,389	24,210	474	491	1,165	30,082
Estimated data (short-range estimate), committee bill:						
1970 ⁴	30,440	28,799	503	523	1,396	32,093
1971	34,133	33,632	597	562	1,491	32,926
1972	36,269	35,263	571	679	1,583	34,265
1973	37,833	36,525	598	732	1,705	35,948
1974	39,574	37,827	625	730	1,928	38,268
1975	48,630	39,156	650	731	2,303	48,664

¹ An interest rate of 4.75 percent is used in determining the level costs, under the intermediate-cost long-range estimates, but in developing the progress of the trust fund a varying rate in the early years has been used.

² A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

³ Not including amounts in the railroad retirement account to the credit of the old-age and survivors insurance trust fund. In millions of dollars, these amounted to \$377 for 1953, \$284 for 1954, \$163 for 1955, \$60 for 1956, and nothing for 1957 and thereafter.

⁴ Estimated data for present law.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service and for the special benefits payable to certain noninsured persons aged 72 or over.

The disability insurance trust fund is estimated to increase by about \$0.8 billion in 1971 under your committee's bill, and by somewhat larger amounts each year thereafter for the next few years. The balance in the disability insurance trust fund, under your committee's bill, would increase from \$6.3 billion at the end of 1971 to \$9.0 billion at the end of 1974, and then to \$10.9 billion at the end of 1975. The trust fund balance at the end of the year during the period 1970-74 closely approximates 2 years' outgo for benefit payments. Table IV presents these short-range estimates.

TABLE IV.—PROGRESS OF DISABILITY INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange ¹	Interest on fund ²	Balance in fund at end of year
Actual data:						
1957.....	\$702	\$57	\$3	-----	\$7	\$649
1958.....	966	249	12	-----	25	1,379
1959.....	891	457	50	-\$22	40	1,825
1960.....	1,010	568	36	-5	53	2,289
1961.....	1,038	887	64	5	66	2,437
1962.....	1,046	1,105	66	11	68	2,368
1963.....	1,099	1,210	68	20	66	2,235
1964.....	1,154	1,309	79	19	64	2,047
1965.....	1,188	1,573	90	24	59	1,606
1966.....	2,022	1,784	137	25	58	1,739
1967.....	2,302	1,950	109	31	78	2,029
1968.....	3,348	2,311	127	20	106	3,025
1969.....	3,615	2,557	138	21	177	4,100
Estimated data (short-range estimate), committee bill:						
1970 ³	4,468	3,093	169	18	259	5,547
1971.....	4,154	3,480	184	17	321	6,341
1972.....	4,324	3,674	182	24	361	7,146
1973.....	4,517	3,824	192	30	411	8,028
1974.....	4,731	3,971	199	30	469	9,028
1975.....	5,716	4,113	208	30	547	10,940

¹ A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

² An interest rate of 4.75 percent is used in determining the level-costs under the intermediate-cost long-range estimates but in developing the progress of the trust fund a varying rate in the early years has been used.

³ Estimated data for present law.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service.

(g) Long-range operations of OASI trust fund

Table V gives the estimated operations of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since nearly all of the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty.

In every year after 1969 for the next 25 years, contribution income under the system as it would be modified by your committee's bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the intermediate long-range cost estimate (with a level-earnings assumption), reaching \$69 billion in 1980 and about \$188 billion at the end of this century. The trust fund is shown as being exhausted in about 65 years, which results from the small lack of actuarial balance, as indicated previously.

TABLE V.—ESTIMATED PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY H.R. 17550, LONG-RANGE INTERMEDIATE-COST ESTIMATE

(In millions)

Calendar year	Contributions	Benefit payments ¹	Administrative expenses	Interest on fund	Balance in fund at end of year
1980.....	\$51,515	\$44,215	\$674	\$2,755	\$68,841
1985.....	54,149	51,198	728	4,639	108,462
1990.....	58,248	58,464	783	5,987	137,324
1995.....	62,723	64,633	831	7,038	160,256
2000.....	67,758	68,556	868	8,275	188,462
2025.....	88,162	114,090	1,276	10,873	237,590
2040.....	101,283	132,683	1,470	(²)	(²)

¹ Includes effect of financial interchange with railroad retirement system.² Fund exhausted in 2035.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the special benefits payable to certain noninsured persons aged 72 or over or for the additional benefits payable on the basis of noncontributory credit for military service after 1955—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

(h) Long-range operations of DI trust fund

The disability insurance trust fund, under the program as it would be changed by your committee's bill, grows slowly but steadily after 1969, according to the intermediate long-range cost estimate, as shown by table VI. In 1980, it is shown as being \$15 billion, while in 1990, the corresponding figure is \$28 billion. There is a small excess of contribution income over benefit disbursements for every year after 1969 for the next 25 years.

TABLE VI.—ESTIMATED PROGRESS OF DISABILITY INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY H.R. 17550, LONG-RANGE INTERMEDIATE-COST ESTIMATE

(In millions)

Calendar year	Contributions	Benefit payments ¹	Administrative expenses	Interest on fund	Balance in fund at end of year
1980.....	\$6,072	\$5,058	\$190	\$618	\$14,578
1985.....	6,465	5,877	199	938	21,455
1990.....	6,882	6,519	210	1,251	28,313
1995.....	7,412	7,293	227	1,581	35,532
2000.....	8,012	8,345	257	1,899	42,420
2025.....	10,390	12,118	369	2,182	48,279
2040.....	11,933	14,235	434	2,109	46,575

¹ Includes effect of financial interchange provision with railroad retirement system.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the additional benefits payable on the basis of noncontributory credit for military service after 1956—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

Table VII shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by your committee's bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs.

TABLE VII.—ESTIMATED COST OF BENEFIT PAYMENTS OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL,¹ UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL

Calendar year	Old-age and survivors insurance benefits	Disability insurance benefits	Total benefits
1980.....	8.32	0.96	9.28
1985.....	9.09	1.05	10.14
1990.....	9.78	1.10	10.88
1995.....	10.07	1.14	11.21
2000.....	9.91	1.21	11.12
2025.....	12.71	1.35	14.06
2040.....	12.87	1.38	14.25
Level-cost ²	9.41	1.10	10.51

¹ Taking into account the lower contribution rate for self-employment income and tips, as compared with the combined employer-employee rate.

² Level contribution rate, at an interest rate of 4.75 percent benefits after 1969 taking into account interest on the trust fund on December 31, 1969, future administrative expenses, the railroad retirement financial interchange provisions, and the reimbursement of noncontributory military-wage-credits cost.

B. ACTUARIAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The hospital insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is in close long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program is relatively new, with little past operating experience, but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one. However, your committee believes that the present cost estimates are made under reasonable assumptions with respect to all foreseeable factors.

New long-range actuarial cost estimates for the hospital insurance system have recently been prepared. They show a significantly higher benefit cost than the previous estimates, which were used as the basis for the 1967 amendments.

These new cost estimates are based on revised assumptions as to the many factors involved in the hospital insurance program. Based on actual recent experience, the assumptions include higher unit costs in the future for hospital and other services covered by the program, an increasing trend in utilization of services, and somewhat higher increases in covered earnings that are subject to contributions. A detailed presentation of the new assumptions is contained in "Actuarial Study No. 71," issued by the Social Security Administration, Department of Health, Education, and Welfare, but some information on these matters is presented in the subsequent discussion here.

(b) *Financing policy*

(1) *Financing basis of H.R. 17550*

The contribution schedule contained in your committee's bill for the hospital insurance program, under a \$9,000 taxable earnings base beginning in 1971, is as follows, as compared with that of present law :

[Percent]

Calendar year	Combined employer-employee rate		Self-employed rate	
	Present law	H.R. 17550	Present law	H.R. 17550
1970.....	1.2	1.2	0.60	0.6
1971-72.....	1.2	2.0	.60	1.0
1973-75.....	1.3	2.0	.65	1.0
1976-79.....	1.4	2.0	.70	1.0
1980-86.....	1.6	2.0	.80	1.0
1987 and after.....	1.8	2.0	.90	1.0

Your committee's bill has not changed the benefit protection provided by the hospital insurance program. However, the bill does contain a number of provisions which are intended to reduce the cost of the program. Among these provisions are the elimination of payments to certain providers of services who have abused the program, the limitation of the payments to certain providers of services who furnish services which are determined to be unduly expensive, certain limitations on financial participation for supporting unnecessary capital expenditures, the possibility of increased economy under prospective-reimbursement experiments and demonstration projects, the limitation of reimbursement to customary charges in certain instances when these are less than reasonable cost, and the requirement of reasonable institutional planning. No recognition of the effect of these cost-reduction changes has been made in the actuarial cost estimates, because it is not possible to quantify them; accordingly, any savings resulting represents a small safety margin in the cost estimates.

An important change made by your committee's bill would permit individuals to obtain their medicare coverage (both hospital insurance and supplementary medical insurance) through a health maintenance organization (a group practice prepayment plan or other capitation plan). In such instances, the medicare program would pay for such coverage on a capitation basis determined by actuarial methods, but not to exceed 95 percent of the amount that, according to actuarial estimates (which would take into account such factors as age and sex of the enrollees, geographical location of the organization, and selection and enrollment rules of the organization), would otherwise have been payable with respect to such persons if they had not been members of such organizations.

No valid experience under the medicare program is available for the purpose of making any cost estimates of the effect of this provision. To the extent that adequate actuarial analysis can be made in the future as to the actual operation of these health maintenance organizations, there could be a significant reduction in the long-run cost of the medicare program.

In the early years of operation, however, there might be slightly increased program costs, because the relatively few organizations of this type now in existence are being reimbursed only their actual costs, whereas under the provisions of your committee's bill, they would, in the future, be reimbursed somewhat more than costs (although possibly less than would have been paid with respect to the participating individuals if they had not belonged to such an organization). On the other hand, if such organizations can supply the covered services at

a lower cost than what would otherwise prevail, then in the future, if more of these organizations are formed, there could be a significant net savings to the program. Accordingly, the actuarial cost estimates have not been modified to reflect the possible cost aspects of this provision for a different reimbursement basis for health maintenance organizations.

Your committee's bill also contains a provision that would eliminate payments under the medicare program for services covered by the Federal employees health benefits plan, beginning in 1972, unless such plan is modified to make available coverage supplementary to that under the medicare program. For the purposes of the actuarial cost estimates, no account is taken of any possible reduction in benefit payments under the medicare program on this account, because of the likelihood that such modification will occur.

Your committee's bill provides an opportunity for persons who are not otherwise eligible under the hospital insurance program to enroll, on a voluntary basis, and then to pay the estimated full cost of the benefit protection thus made available. Such voluntary elective individual coverage can also be obtained by States and other organizations on a group basis for their retired employees aged 65 and over who are not otherwise protected under the hospital insurance program.

The actuarial cost estimates presented in this report do not take into account the effect of this provision for voluntary coverage of otherwise ineligible persons, since it is not possible to estimate how many of the approximately 250,000 persons eligible to so elect will actually do so; of these 250,000 persons, about 145,000 are covered under the Federal Employees Health Benefits plan and so are unlikely to elect the voluntary hospital insurance under the bill. Thus, approximately 100,000 persons are really potentially eligible to elect. Furthermore, if the premium rate, which has been actuarially estimated at \$27 per month for the first 1½ years of operation, is adequate, there will be no net effect on the financial operations of the total program. In any event, whether or not such experience is favorable, there will be relatively little effect on the financial operations of the program, because of the small number of persons likely to be involved.

The hospital insurance program is completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base is the same under both programs. *First*, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). *Second*, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. *Third*, income tax withholding statements (forms W-2) show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. *Fourth*, the hospital insurance program covers railroad employees directly in the same manner as other covered workers, and their benefit payments are paid directly from this trust fund (rather than

directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). *Fifth*, the financing basis for the hospital insurance system is determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years, instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one). *Sixth*, the contribution rate for self-employed persons is the same as for employees, whereas under old-age, survivors, and disability insurance, the self-employed pay 50 percent more at the present time.

(2) *Self-supporting nature of system*

Just as has always been the case in connection with the old-age, survivors, and disability insurance system, your committee has very carefully considered the cost aspects of the present hospital insurance system and proposed changes therein. In the same manner, your committee believes that this program should be completely self-supporting from the contributions of covered individuals and employers (the transitional uninsured group covered by this program have their benefits, and the resulting administrative expenses, completely financed from general revenues). Accordingly, your committee very strongly believes that the tax schedule in the law should make the hospital insurance system self-supporting over the long range as nearly as can be foreseen, and thus actuarially sound.

(3) *Actuarial soundness of system*

The concept of actuarial soundness as it applies to the hospital insurance system is somewhat similar to that concept as it applies to the old-age, survivors, and disability insurance system (see discussion of this topic in another section), but there are important differences.

One major difference in this concept as it applies between the two different systems is that cost estimates for the hospital insurance program should desirably be made over a period of only 25 years in the future, rather than 75 years as in connection with the old-age, survivors, and disability insurance program. A shorter period for the hospital insurance program is necessary because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit. Although there is reasonable likelihood that the number of beneficiaries aged 65 and over will tend to increase over the next 75 years when measured relative to covered population (so that a period of this length is both necessary and desirable for studying the cost of the cash benefits under the old-age, survivors, and disability insurance program), it is far more difficult to make reasonable assumptions as to the trends of medical care costs and practices for more than 25 years in the future.

It seems desirable to your committee that the hospital insurance program should be in close actuarial balance. In order to accomplish this result, your committee has revised the contribution schedule to meet this requirement, according to the underlying cost estimates.

(c) *Hospitalization data and assumptions*(1) *Past increases in hospital costs and in earnings*

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1955 and up through 1969.

TABLE A.—COMPARISON OF ANNUAL INCREASES IN HOSPITAL COSTS AND IN EARNINGS

Calendar year	[Percent]	
	Average wages in covered employment ¹	Average daily hospitalization costs ²
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
1964	3.1	6.9
1965	1.6	7.0
1966	4.4	8.3
1967	6.3	12.3
1968	7.0	13.5
1969	6.0	³ 14.0
Average for 1956-65	3.6	6.8
Average for 1966-69	5.9	12.0

¹ Data are for calendar years (based on experience in 1st quarter of year).

² Data are for fiscal years ending in September of year shown. Data are from American Hospital Association, and "hospitalization costs" represents total hospital expense per patient day.

³ Preliminary estimate made by Social Security Administration.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospital costs are based on a series of average daily expense per patient day (including not only room and board, but also other inpatient charges and other expenditures of hospitals) prepared by the American Hospital Association.

The annual increases in earnings fluctuated somewhat over the period up through 1965, although there were not very large deviations from the average annual rate of 3.6 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise fluctuated from year to year during this period, around the average annual rate of 6.8 percent.

During the period 1955-65, hospital costs increased at a faster rate than earnings. The differential between these two rates of increase fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 3.2 percent.

Following 1965, however, both earnings and hospital costs have risen sharply, the former at a rate of about 6 percent per year and the latter at about 12 percent per year. Thus, the differential rate

of increase of hospital costs as against earnings was about 6 percent per year during 1966-69, as compared with 3 percent in the preceding decade. Or, to put it another way, in the past 15 years, hospital costs have increased at double the rate that earnings in general have. No change in this relationship is evident currently, so that relatively high increases in hospital costs seem likely in at least the next few years.

Your committee was advised by the Department of Health, Education, and Welfare that, in the future, after the next few years, earnings are estimated to increase at a rate of about 4 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be.

(2) *Effect on cost estimates of rising hospital costs*

A major consideration in making cost estimates for hospital benefits, then, is how long and to what extent the tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future, and whether or not it may, in the long run, be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense.

In connection with this latter factor, there are possible counterbalancing factors. The higher costs involved for more refined and extensive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making actuarial cost estimates for hospital benefits is that—unlike the situation in regard to cost estimates for monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the financing provisions of the system are kept up to date (insofar as the maximum taxable earnings base is concerned). The reason for this result is that hospital costs rise at least at the same rate over the long run as the total earnings level, whereas the contribution income rises less rapidly, unless the earnings base is kept up to date, than the total earnings level.

For these reasons, the cost estimates were previously based on the assumption that both hospital costs and the general level of earnings will increase in the future for the entire 25-year period considered, while at the same time the earnings base will not change. The present cost estimates no longer assume that the maximum taxable earnings base will not change, but rather that it will be kept up to date, by periodic legislative revisions, with changes in the general level of earnings; such situation has been the case for the last two decades, and it seems reasonable that it will continue in the future.

Your committee believes that such a less conservative assumption, resulting in a reduced safety margin, is now justifiable and proper. Initially, such a safety factor was needed when there was no firm indication of what the actual near-future experience would be. Now, good data are available as to the actual current experience, and so such a margin is no longer necessary if adequately reasonable assumptions are adopted as to future trends of unit costs of services and of utilization of services. Quite obviously, if the earnings base is not changed in the future to keep it up to date in this manner, and if the actual experience develops in line with the assumptions made in the actuarial cost estimates, then higher contribution rates than now provided under your committee's bill would be necessary.

The fact that the cost-sharing provisions (the initial hospital deductible and the coinsurance features) are on a dynamic basis which varies with hospital costs is taken into account as not requiring a higher cost estimate than would be needed if static conditions were assumed.

(3) *Assumptions as to relative trends of hospital costs and earnings underlying cost estimate for H.R. 17550*

As indicated previously, your committee very strongly believes that the financing basis of the hospital insurance program should be developed on a conservative basis. For the reasons brought out, the cost estimates should not be developed on a level-earnings basis, but rather they should assume dynamic conditions as to both earnings levels and hospitalization costs. Accordingly, it seems appropriate to make cost projections for only 25 years in the future and to develop the financing necessary for only this period (but with a resulting trust fund balance at the end of the period equal to about 1 year's disbursements). Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-utilization and medical-practice trends will be in the distant future.

The assumptions as to the short-term trend of hospital costs for the cost estimates presented here are shown in table B.

Table B.—Assumptions as to future rates of increase in hospital costs

Calendar year:	Rate of increase (in percent)
1969 -----	15.0
1970 -----	14.0
1971 -----	13.0
1972 -----	11.5
1973 -----	10.0
1974 -----	8.5
1975 -----	7.0
1976 -----	6.0
1977 -----	5.0
1978 and after -----	4.0

(4) *Assumptions as to hospital utilization rates underlying cost estimates for H.R. 17550*

The hospital utilization assumptions for the cost estimates in this report are founded on the hypothesis that current practices in this field will not change even more in the future than past experience

has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for your committee's bill are based on the actual experience of the program in 1968, with assumed increases of 1 to 2 percent per year for the next decade.

(5) *Assumptions as to hospital per diem rates underlying cost estimates for H.R. 17550*

The average daily hospital reimbursement rate by the program for 1968 (i.e. not including the cost-sharing payments made by the beneficiaries) was about \$48. This was projected for future years in the manner described previously.

(d) *Results of cost estimates*

(1) *Summary of cost estimate for H.R. 17550*

The level-cost of the benefits and administrative expenses under present law is estimated at 2.06 percent of taxable payroll under the assumption that the earnings base will be changed, after 1970, to keep up to date with the general level of earnings (as the increase to \$9,000 in 1971 in your committee's bill does). Such level-cost would be 2.79 percent of taxable payroll if it were assumed that the earnings base would remain fixed at \$7,800 over the entire 25-year valuation period—the assumption underlying previous actuarial evaluation of the program.

Under the rising-earnings-base assumption, the level-equivalent of the graded contribution schedule under present law is 1.56 percent of taxable payroll and the level-equivalent value of the existing trust fund is 0.02 percent of taxable payroll, so that there is a lack of actuarial balance under present law, using the revised estimates of hospital cost trends and the other revised cost factors, amounting to 0.48 percent of taxable payroll. Under the assumption that the earnings base remains level in the future at the \$7,800 amount specified in present law (the assumption which has heretofore been made in setting the contribution schedule), the level-equivalent of the contribution schedule is 1.52 percent of taxable payroll, and the level-equivalent of the existing trust fund is 0.03 percent of taxable payroll, so that then the actuarial balance would be -1.24 percent of taxable payroll.

Under your committee's bill, there would be additional financing for the program, both through the increase in the earnings base to \$9,000, effective in 1971, and through increasing the rates in the contribution schedule. Thus, the new contribution schedule (which has a level-equivalent value of 1.98 percent of taxable payroll) would, under the current cost estimate, adequately finance the program, whose actuarial balance would then be -0.06 percent of taxable payroll.

Table C traces through the actuarial balance of the hospital insurance system from its situation under present law, according to the latest estimate, to that under your committee's bill, determined as of January 1, 1970.

TABLE C.—CHANGES IN ACTUARIAL BALANCE OF HOSPITAL INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, INTERMEDIATE-COST ESTIMATE, PRESENT LAW AND H.R. 17550

Item	[Percent]			
	Level-cost or level-equivalent			Actuarial balance
	Contributions	Benefit payments ¹	Existing trust fund	
Present law, level \$7,800 earnings base	1. 52	2. 79	0. 03	-1. 24
Present law, increasing earnings base ²	1. 56	2. 06	. 02	— . 48
Committee bill, increasing earnings base ²	1. 98	2. 06	. 02	— . 06

¹ Including also the administrative expenses.

² The cost estimate is made under the assumption that the maximum taxable earnings base will be kept up to date after 1970, so that approximately the same proportion of the total payroll in covered employment will be taxable as was the case under the \$7,800 base in 1968. This would produce a base of \$9,000 in 1971 (as in your committee's bill) and, under the assumptions made as to future changes in earnings levels, \$10,200 in 1973 (if changed then), and similarly \$10,800 in 1975, \$12,000 in 1977, etc., to \$22,200 in 1993.

The cost for the persons who are blanketed-in for the hospital and related benefits is met from the general fund of the Treasury (with the financial transactions involved passing through the hospital insurance trust fund). The costs so involved, along with the financial transactions, are not included in the preceding cost analysis, although they are shown in the following discussion of the progress of the hospital insurance trust fund. A later portion of this section, discusses these costs for the blanketed-in group.

(2) *Future operations of hospital insurance trust fund*

Table D shows the estimated operation of the hospital insurance trust fund under present law (assuming no change in the \$7,800 earnings (base), while table E gives similar figures for your committee's bill (under the assumption that the \$9,000 earnings base effective in 1971 will be kept up to date with rising earnings levels in the future).

Under present law, outgo exceeds income for every year after 1969. As a result, the trust fund is shown as being exhausted in mid-1972. According to this estimate, under your committee's bill the balance in the trust fund would grow steadily in the future, increasing from about \$2.2 billion at the end of 1970 to \$14.2 billion 5 years later; over the long range, the trust fund would build up steadily, reaching a peak of \$23 billion in 1985 and then decreasing to \$13.8 billion in 1994 (at which time it represents somewhat less than 6 months' benefit outgo). The reason for the decrease in the trust-fund balance in the last decade of the 25-year valuation period and for the fund at the end of the period being less than 1 year's outgo is that the actuarial balance of the system is a small negative amount. If the experience were to follow exactly the underlying assumptions in the cost estimate, a small amount of additional financing would ultimately be necessary.

TABLE D.—ESTIMATED PROGRESS OF HI TRUST FUND UNDER PRESENT FINANCING PROVISIONS, INCURRED BASIS

[In millions]

Calendar year	Contributions ¹	Government payment for uninsured ²	Benefit payments	Administrative expenses	Interest on fund ³	Net income	Fund at end of year
1970-----	\$4, 973	\$618	\$5, 820	\$140	\$139	—\$230	\$2, 183
1971-----	5, 231	656	6, 894	150	101	—1, 056	1, 127
1972-----	5, 482	685	8, 031	161	8	—2, 017	(4)

¹ Includes payments from general fund for military service wage credits.² Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).³ Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.⁴ Fund exhausted in 1972.

Note: Fund balance at beginning of 1970 is \$2,413 million on an incurred basis (as compared with \$2,505 million on a cash basis).

TABLE E.—ESTIMATED PROGRESS OF HI TRUST FUND UNDER FINANCING PROVISIONS OF COMMITTEE BILL UNDER BASIS OF EARNINGS BASE BEING KEPT UP TO DATE WITH INCREASES IN EARNINGS,¹ INCURRED BASIS

[In millions]

Calendar year	Contributions ²	Government payment for uninsured ³	Benefit payments	Administrative expenses	Interest on fund ⁴	Net income	Fund at end of year
1970-----	\$4, 973	\$618	\$5, 820	\$140	\$139	—\$230	\$2, 183
1971-----	9, 252	656	6, 894	150	226	3, 090	5, 273
1972-----	9, 728	685	8, 031	161	389	2, 610	7, 883
1973-----	10, 721	701	9, 204	172	534	2, 580	10, 463
1974-----	11, 224	701	10, 383	183	657	2, 016	12, 479
1975-----	11, 997	688	11, 477	195	753	1, 766	14, 245
1980-----	15, 978	490	16, 138	260	1, 024	1, 094	20, 371
1985-----	20, 860	282	21, 462	345	1, 109	444	22, 955
1990-----	26, 812	116	28, 586	457	1, 029	—1, 086	20, 552
1994-----	32, 249	45	35, 500	560	749	—3, 017	13, 842

¹ Maximum taxable earnings base would be \$7,800 in 1970, \$9,000 in 1971-72, \$10,200 in 1973-74, \$10,800 in 1975-76, \$12,000 in 1977-78, increasing ultimately to \$22,200 in 1993-94. Combined employer-employee contribution schedule would be 1.2 percent for 1970, and 2.0 percent for 1971 and after.² Includes payment from general fund for military service wage credits.³ Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).⁴ Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.*(3) Cost estimate for hospital benefits for noninsured persons paid from general funds*

Hospital and related benefits are provided not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also on a "free" basis for most other persons who were aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. The exceptions are non-insured persons who are active and retired Federal employees who are eligible (or had the opportunity of being eligible) for similar protection under the Federal Employees Health Benefits Act of 1959 or who are short-residence aliens.

Under present law, persons meeting such conditions who attain age 65 before 1968 qualify for the hospital benefits regardless of whether they have had any covered employment in the past, while those attaining age 65 after 1967 must have some such coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1966 and before the year of attain-

ment of age 65 (e.g., 3 quarters of coverage for attainment of age 65 in 1968, 6 quarters for 1969, etc.). This transitional provision "washes out" under present law for men attaining age 65 in 1975 and for women attaining age 65 in 1974, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

Under your committee's bill, these requirements for noninsured men would "wash out" at the same time as for women (due to the "age-62 computation point for men" provision in your committee's bill).

The benefits for the noninsured group who receive hospital insurance benefits on a "free" basis is to be paid from the hospital insurance trust fund, but with financial reimbursement therefor from the general fund of the Treasury on a current basis, or with appropriate interest adjustment. The estimated cost to the general fund of the Treasury for the hospital and related benefits for this noninsured group (including the applicable additional administrative expenses) for various future years is shown in Table E. The estimated cost to the general fund of the Treasury for the closed group involved increases slowly to a peak of about \$700 million per year in 1973-74 and then decreases steadily thereafter. Offsetting, in large part, the decline in the number of eligibles blanketed-in are the factors, the increasing hospital utilization per capita as the average age of the group rises and the increasing hospital costs in future years.

The foregoing discussion and cost estimates do not include the non-insured persons who, under the provisions of your committee's bill, can voluntarily buy into the hospital program on the basis of their paying the estimated full costs involved.

C. ACTUARIAL COST ESTIMATES FOR THE SUPPLEMENTAL MEDICAL INSURANCE SYSTEM

(a) Summary of actuarial cost estimates

Your committee's bill has broadened slightly the benefit protection provided by the supplementary medical insurance program. The only such changes that are significant from a cost standpoint are the provision of certain limited physical therapy services provided in the office of the physical therapist or in the patient's home which are not under the supervision of an institutional provider of services and making the deductible and coinsurance provisions inapplicable to the professional component of services performed by certain teaching physicians in hospitals.

Your committee's bill also contains a number of provisions which are intended to reduce the cost of the supplementary medical insurance program. Among these provisions are the establishment of limits on prevailing charge levels (using the 75th percentile for fiscal year 1971 and adjusting the levels thereafter by means of an appropriate economic index), tightening up the reimbursement provisions for teaching physicians who furnish inpatient services, and several provisions eliminating payments to certain providers of services who have abused the program and limiting the payments to certain providers of services who furnish services which are determined to be unduly expensive.

No account is taken in the actuarial cost estimates for the supplementary medical insurance program of the provisions of your commit-

tee's bill that provide for medicare coverage to be obtained from health maintenance organizations or for medicare benefits to be withheld (after 1971) if benefits are payable to the individual under the Federal employees health benefits plan, unless such plan is coordinated with medicare. The reasons for not considering such provisions are given in the section dealing with the actuarial cost estimates for the hospital insurance system.

The cost effects of these changes will be recognized by the Secretary of Health, Education, and Welfare in his determination of the standard premium rate for fiscal year 1972, which in accordance with the provisions of present law will be promulgated in December 1970.

(b) *Financing policy*

(1) *Self-supporting nature of system*

Coverage under supplementary medical insurance can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and over in the United States. This program is intended to be completely self-supporting from the premiums of enrolled individuals and from the equal-matching contributions from the general fund of the Treasury. For the initial period, July 1966 through December 1967, the premium rate was established by law at \$3 per month, so that the total income of the system per participant per month was \$6. Persons who do not elect to come into the system at as early a time as possible generally have to pay a higher premium rate. The standard monthly premium rate is now adjusted annually by promulgation of the Secretary of Health, Education, and Welfare (using appropriate actuarial methods), so as to reflect the expected experience on an incurred-cost basis, including an allowance for a margin for contingencies. All financial operations for this program are handled through a separate fund, the supplementary medical insurance trust fund.

(2) *Actuarial soundness of system*

The concept of actuarial soundness for the old-age, survivors, and disability insurance system and for the hospital insurance system is somewhat different than that for the supplementary medical insurance program. In essence, the last system is on a "current cost" financing basis, rather than on a "long-range cost" financing basis. The situations are essentially different because the financial support of the supplementary medical insurance system comes from a premium rate that is subject to change from time to time, in accordance with the experience actually developing and with the experience anticipated in the near future. The actuarial soundness of the supplementary medical insurance program, therefore, depends only upon the "short-term" premium rates being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are established (including the accumulation and maintenance of a contingency fund).

(c) *Results of cost estimates*

Your committee's bill makes a number of changes in the provisions of the supplementary medical insurance program, of which some expand its scope whereas several limit the scope or reduce costs. The only changes which have a significant cost effect are: (1) the elimination of the cost-sharing for the professional component of inpatient services

furnished by certain teaching physicians, effective on enactment; (2) the provision of benefits for certain additional physical therapy services, effective January 1, 1971; and (3) the establishment of limits on prevailing charge levels, effective July 1, 1970.

No significant cost effect is estimated for the higher reimbursement basis for certain teaching physicians, because payments for some of these services will be based on reasonable costs (rather than on reasonable charges) under your committee's bill.

The liberalized physical therapy benefits are estimated to have a cost of about \$.03 per month per enrollee, or a total annual cost of about \$7 million.

The lower limits established for the prevailing charge levels are estimated to reduce costs by about 1 to 2 percent in the first year of operation, or by about \$20 to \$40 million in fiscal year 1971. It is not possible to estimate the effect on in costs for subsequent years, because the appropriate economic index has yet to be prescribed by the Secretary of Health, Education, and Welfare.

The net effect of the changes that would be made by your committee's bill for the forthcoming premium period beginning July 1, 1970 (for which a standard premium rate of \$5.30 per month has been promulgated by the Secretary of Health, Education, and Welfare), is a net reduction in benefit costs of about \$17 to \$37 million, resulting from an increased cost of \$3 million for the additional physical therapy benefits (which are available beginning January 1, 1971) and a decreased cost of \$20 to \$40 million due to the lower limits on prevailing charge levels. As a result, the actuarial status of the program is slightly improved, and the premium rate will contain a somewhat larger margin for contingencies.

V. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill—the “Social Security Amendments of 1970”—and the table of contents.

TITLE I—PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

SECTION 101. INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Section 101 of the bill provides a benefit increase of 5 percent, effective January 1, 1971, with new minimum and maximum benefit amounts.

Primary insurance amount; column IV of the revised benefit table

Section 101(a) of the bill amends section 215(a) of the Social Security Act to substitute a new table for the present benefit table. The new table effectuates the benefit increase for people who are on the benefit rolls prior to January 1971 and provides benefit amounts higher than those under present law for people who come on the benefit rolls in or after that month. The new primary insurance amounts, shown in column IV of the table, represent an increase of 5 percent over the primary insurance amounts provided in present law for average monthly earnings up to \$650—the highest average monthly earnings possible under present law. (The primary insurance amount is the monthly benefit payable to a worker who retires at or after age 65 or to a disabled worker who had not previously been entitled to a reduced old-age benefit; it is also the amount on which all other benefits are based.)

An approximation of the benefits shown in the new benefit table can be arrived at by taking 85.92 percent of the first \$110 of average monthly earnings, plus 31.25 percent of the next \$290, plus 29.20 percent of the next \$150, plus 34.32 percent of the next \$100, plus 20 percent of the next \$100. Benefits in the table in present law approximate 81.83 percent of the first \$110 of average monthly earnings, plus 29.76 percent of the next \$290, plus 27.81 percent of the next \$150, plus 32.69 percent of the next \$100.

The primary insurance amounts provided by the new table range from a minimum of \$67.20 for people whose average monthly earnings are \$76 or less to a maximum of \$283 for people who have average monthly earnings of \$750. Average monthly earnings as high as \$750 will become possible in the future under the \$9,000 contribution and benefit base which the bill (in sec. 120) provides. The primary insurance amounts of workers getting benefits based on present law (i.e., workers who will not have the advantage of the increased contribution and benefit base) are raised from \$64 to \$67.20 at the minimum and from \$250.70 to \$263.30 at the maximum payable in 1971.

The total monthly amount of benefits payable to a family on the basis of a single earnings record, shown in column V of the table, is $1\frac{1}{2}$ times the worker's primary insurance amount up to the last point (average monthly earnings of \$267) at which $1\frac{1}{2}$ times the worker's primary insurance amount is greater than 80 percent of the worker's average monthly earnings. Above that point, the maximum family benefit is equal to the sum of 80 percent of the worker's average monthly earnings up to \$436 (about 58 percent of the maximum possible average monthly earnings—\$750 under a \$9,000 contribution and benefit base) plus 40 percent of the worker's average monthly earnings above \$436. This formula produces, at the maximum possible average monthly earnings of \$750, a maximum family benefit of almost two-thirds of the average monthly earnings. Under the bill, the maximum amount of monthly benefits payable to a family will range from \$100.80 to \$474.40.

Maximum family benefits for people already on the rolls

Section 101(b) of the bill amends section 203(a)(2) of the act to assure an increase in family benefits for families with two or more members who are entitled to benefits for January 1971 if at least one of them was entitled to benefits in December 1970. Under the bill, the total of benefits payable to such families may not be reduced to less than the larger of (1) the family maximum specified in column V of the new table or (2) the sum of all the benefits of family members on the benefit rolls in December 1970 computed under present law, increased by 5 percent, and rounded to the next higher 10 cents if not already a multiple of 10 cents. Without such a provision, some families now on the rolls could receive little or no increase in benefits.

Section 101(b) of the bill also contains a provision affecting the amount of benefits for family members getting benefits in January 1971 on the basis of two or more earnings records. Under present law, when children are entitled to benefits on the earnings records of more than one worker, the total benefits payable to the family are not reduced to less than the smaller of the sum of the maximum family benefits payable on all the earnings records on which the family members could be entitled or the highest family maximum benefit shown in column V of the benefit table. Under the bill, in cases in which the combined-family-maximum provisions (sec. 202(k)(2)(A) of the act) are applicable, these provisions are applied before the provisions of section 203(a) which guarantee every beneficiary a 5-percent increase—that is, the provisions of the bill which guarantee a 5-percent increase to each member of the family (described above) are applied last. When the combined-family-maximum cases in which the combined family maximum provisions (sec. 202(k)(2)(A) of present law) are applicable, these provisions are applied before the provisions of section 203(a) which guarantee every beneficiary a 5-percent increase—that is, the provisions of the bill which guarantee a 5-percent increase to each member of the family (described above) are applied last. When the combined-family-maximum provisions are applicable in the effective month of the benefit increase, and later cease to apply because the benefits for the last family member entitled on more than one earnings record are terminated, the benefit amounts for the remaining family members, who are entitled on a single earnings record, will be determined under

section 203(a)(2), as amended by the bill, as if they had been getting benefits based on only one earnings record in January 1971.

Average monthly earnings: column III of the revised benefit table

Section 101(c) of the bill amends section 215(b)(4) of the act so that column III of the new benefit table will be applicable only in the case of an average monthly earnings computation for a person (1) who becomes entitled to old-age or disability insurance benefits in or after January 1971, or (2) who dies in or after that month without having been entitled to old-age or disability benefits, or (3) whose benefit is recomputed for months beginning with or after that month.

Primary insurance amount under 1969 act; column II of the revised benefit table

Section 101(d) of the bill amends section 215(c) of the act to provide that a person who becomes entitled to old-age or disability insurance benefits before January 1971, or who dies before that month, will have his primary insurance amount determined under the provisions of present law for purposes of column II of the revised table. Since benefit amounts appearing in column II of the revised table will be converted to the new benefit amounts in column IV of that table, the effect of this provision is that people already on the rolls will have their benefits converted to the higher primary insurance amount appearing on the same line in column IV of the new table. Under present law, column II of the benefit table shows the primary insurance amounts in effect prior to the Social Security Amendments of 1969, and column IV of the table shows the amounts to which the primary insurance amounts in column II were converted as a result of those amendments.

Effective date

Section 101(e) of the bill provides that the benefit increases under section 101 will be effective for monthly benefits for and after January 1971 and for lump-sum death payments where death occurs in or after that month.

Special provision for conversion of a disability insurance benefit to an old-age insurance benefit

Section 101(f) of the bill is a special transitional provision which applies to a person who is entitled to a disability insurance benefit for December 1970 and who becomes entitled to old-age insurance benefits (for example, by reason of attainment of age 65), or dies, in January 1971, to make certain that his primary insurance amount is increased. The general rule, provided in section 215(a)(4) of the act, that would otherwise apply in this situation is that an individual who was entitled to a disability insurance benefit for the month before the month for which he becomes entitled to an old-age insurance benefit will have as his primary insurance amount the amount in column IV of the table that is equal to the primary insurance amount on which his disability insurance benefit is based. In the above situation, the individual's disability insurance benefit, since it was derived from a primary insurance amount determined under present law, does not have any direct connection with column IV of the table included in the bill, which contains the new benefit amounts; thus, the general rule cannot be applied to him. Therefore, section 101(f) of the bill provides that his

primary insurance amount will be the amount in column IV of the table on the same line as that on which, in column II, appears his present primary insurance amount. (The primary insurance amount be applied to him. Therefore, section 101(f) of the bill provides that his disability insurance benefit under present law is based.)

SECTION 102. INCREASE IN BENEFITS FOR CERTAIN INDIVIDUALS AGE 72 AND OVER

Section 102 of the bill increases the amount of the special payments made to certain people age 72 and older who have never worked in covered jobs or who have had less covered work than is needed to qualify for the regular retirement benefits of the program.

Section 102(a) of the bill amends section 227 of the Social Security Act to increase from \$46 to \$48.30 the monthly amount payable to transitionally insured workers and widows who qualify for special payments under section 227 on the basis of 3, 4, or 5 quarters of coverage. (To qualify for regular retirement benefits, a worker has to have a minimum of 6 quarters of coverage.) It also raises from \$23 to \$24.20 the amount payable to the wives of men who qualify for benefits under that section.

Section 102(b) of the bill amends section 228 of the act to increase from \$46 to \$48.30 the monthly amount payable to people who qualify under section 228 on the basis of no quarters of coverage, or of some quarters of coverage but not enough to qualify for either regular retirement benefits or payments to transitionally insured people, and to increase from \$23 to \$24.20 the monthly amount payable to a wife when both husband and wife are entitled to benefits under that section.

Section 102(c) of the bill provides that these increases in the amounts of the special payments will be effective with respect to monthly payments for and after January 1971.

SECTION 103. INCREASED WIDOW'S AND WIDOWER'S INSURANCE BENEFITS

Section 103 of the bill provides increased widow's and widower's benefits for those who become entitled to such benefits after age 62. A widow or widower who first becomes entitled to benefits at or after age 65 can get a benefit equal to 100 percent of the primary insurance amount of the deceased worker. A widow's benefit amount is to be actuarially reduced by $57/120$ per month for each month for which the benefit is paid before age 65, so that the benefit is 82.9 percent of the worker's primary insurance amount at age 62 and 71.5 percent at age 60.

Section 103(a)(1) of the bill amends section 202(e) of the Social Security Act to change the amount of an unreduced widow's benefit from $82\frac{1}{2}$ percent of the worker's primary insurance amount to 100 percent.

Section 103(a)(2) of the bill amends section 202(e) of the act to provide that reduced wife's benefits and mother's benefits will be automatically converted to widow's benefits at age 65 rather than at age 62 so that a woman whose husband dies while she is between ages 62 and 65 can choose whether to take a reduced widow's benefit or wait until age 65 and get a full widow's benefit. It also provides that a disabled widow's benefit will be automatically converted to

an aged widow's benefit at age 65 rather than at age 62 so that a woman who recovers from a disability between ages 62 and 65 can choose whether to apply for reduced aged widow's benefits or wait until age 65.

Section 103(b)(1) of the bill amends section 202(f) of the act to change the amount of an unreduced widower's benefit from 82½ percent of the worker's primary insurance amount to 100 percent.

Section 103(b)(2) of the bill amends section 202(f) of the act to provide that reduced husband's benefits will be automatically converted to widower's benefits at age 65 rather than at age 62 so that a man whose wife dies while he is between ages 62 and 65 can choose whether to take a reduced widower's benefit or wait until age 65 and get a full widower's benefit.

Section 103(b)(3) amends section 202(f) of the act to provide that a disabled widower's benefit will be automatically converted to an aged widower's benefit at age 65 rather than at age 62 so that a man who recovers from a disability between ages 62 and 65 can choose whether to apply for reduced aged widower's benefits or wait until age 65.

Section 103(c)(1) and section 103(c)(2) of the bill amend section 203 of the act to eliminate the application of the retirement test to disabled widows and widowers until age 65 when the benefit based on a disability is converted to an aged widow's or widower's benefit.

Section 103(d)(1) of the bill amends section 202(q)(1) of the act to eliminate for widows and widowers the actuarial reduction factor of $\frac{5}{9}$ of 1 percent per month from age 60 to 62 and to substitute a new factor of $\frac{5}{120}$ of 1 percent from age 60 to 65. This change in the actuarial reduction factor for disabled widows and widowers is made in order to provide benefits between age 50 and 60 equal to those provided under present law. The benefit payable at age 50 equals 50 percent of the deceased worker's primary insurance amount.

Section 103(d)(2) of the bill amends section 202(q)(7) of the act to revise (in the light of the other amendments made by section 103) the description of the periods over which old-age, wife's, husband's, widow's, and widower's benefits are actuarially reduced, and to provide for a recomputation of benefits at age 62 and at age 65 to adjust the number of months in the period over which benefits are actuarially reduced. This adjustment is necessary to eliminate the reduction for months when actuarially reduced benefits were not received—for example, when benefits were withheld because of earnings from work. Under present law this recomputation is only provided for widows at age 62 and widowers at age 62 and for other beneficiaries at age 65.

Section 103(d)(3) of the bill amends section 202(q)(9) of the act to change the definition of retirement age for widows and widowers to age 65 as is now the case for old-age, wife's, and husband's insurance benefits.

Section 103(e)(1) of the bill amends section 202(m) of the act, which provides (in paragraph (1)) that the benefit of a sole surviving beneficiary will not be less than the minimum primary insurance amount.

Paragraph (2) of the amended section 202(m) deals specifically with benefits for a sole surviving widow or widower; it provides that such benefits when based upon an application filed between ages 62

and 65 will not be less than the minimum benefit, and when based upon an application filed between ages 60 and 62 will not be less than the minimum benefit reduced by the amount by which it would be reduced if the beneficiary had attained age 65 when he actually attained or would attain age 62. The maximum reduction that would apply to the minimum benefit in the latter case would be for 24 months.

Paragraph (3) of the amended section 202(m) provides that in determining the amount of a disabled widow's or widower's benefit when paragraph (2) applies, the amount of the reduction for months between ages 50 and 60 will be based on the person's actual age rather than the fictitious age used in determining the reduction applicable under paragraph (2). Thus the benefit for a 50-year-old disabled widow will be either a benefit equal to her husband's primary insurance amount reduced by $\frac{5}{120}$ of 1 percent per month for the 60 months between ages 60 and 65 and $\frac{43}{240}$ of 1 percent per month for the 120 months between ages 50 and 60 (as provided in section 202(q)(1) of the act as amended by section 103(d)(1) of the bill) or the minimum benefit reduced by $\frac{5}{120}$ of 1 percent per month for the 120 months between ages 50 and 60 based on the person's actual age, whichever is larger.

Section 103(f) of the bill directs the Secretary to redetermine the amount of the widow's and widower's benefits for those entitled in December 1970 as if the amendments made by section 103 had been available at the time of their initial entitlement; the redetermined amounts are to be effective for January 1971.

Section 103(g) of the bill provides that family members entitled on the same account as a widow or widower whose benefit is increased under the amendments made by section 103 will not have their benefits decreased as a result of the increase in the widow's or widower's benefit.

Section 103(h) of the bill provides that these amendments will be effective for monthly benefits beginning with January 1971.

SECTION 104. AGE-62 COMPUTATION POINT FOR MEN

Section 104 of the bill provides for determining the number of years to be used in figuring a man's insured status and the average monthly earnings on which his benefits are based by taking into account only the period up to age 62, as is the case for women, rather than up to age 65 as under present law.

Section 104(a) of the bill amends section 214(a)(1) of the Social Security Act to provide that benefit eligibility of a male worker will be based on the number of years up to the year in which he attains age 62, rather than up to the year in which he attains age 65 as under present law.

Section 104(b) of the bill amends section 215(b)(3) of the act to provide that, in determining the number of years to be used in figuring the average monthly earnings of a male worker, there will be taken into account only years up to the year in which he attains age 62 rather than up to the year in which he attains age 65 as under present law.

Section 104(c) of the bill provides that the primary insurance amount of an insured individual who, prior to January 1971, becomes entitled to an old-age insurance benefit, becomes entitled to a disability

insurance benefit after the year in which he attains age 62, or dies in a year after the year in which he attains age 62 will be recomputed using earnings only up to age 62 rather than up to age 65.

Section 104(d) of the bill amends section 223(a)(2) of the act to provide that the disability insurance benefit of a male worker will be computed as though he attained age 62 in the first month of his waiting period or, when the waiting period is waived, the first month of his entitlement to disability benefits. Elapsed years for the disability benefit computation will not include the year he attains age 62 or any year thereafter.

Section 104(e) of the bill amends section 223(c)(1)(A) of the act to make the reference to a fully insured individual therein applicable to any individual who had attained age 62 with no distinction between a man and a woman.

Sections 104(f) and (g) of the bill amend sections 227(a)(1) and 227(b) of the act to make conforming changes in the transitional insured status provisions.

Section 104(h) of the bill amends sections 209(i), 213(a)(2) and 216(i)(3)(A) of the act to make certain references therein applicable to an individual who attains age 62 with no distinction between a man and a woman.

Section 104(h) of the bill amends sections 209(i), 213(a)(2), and 303(g)(1) of the Social Security Amendments of 1960 to provide that the primary insurance amount of an individual age 62 before 1961 can continue to be computed under the provisions of the act before the amendments of 1960.

Section 104(j) of the bill amends section 3121(a) of the Internal Revenue Code of 1954 to provide that wages for social security tax purposes will not include any payment (other than sick or vacation pay) made to an employee after the month in which he attains age 62 with no distinction between a man and a woman, if the employee did not work for the employer in the period for which the payment is made.

Section 104(k) of the bill (a saving clause) provides that, if the monthly benefits of individuals entitled under section 202 or 223 of the act are redetermined in accordance with section 104 of the bill, the total benefits for the family will not be less than the amount to which they were entitled in January 1971 plus the amount of the increase in the insured individual's primary insurance amount.

Section 104(l) of the bill provides that these amendments will be effective for monthly benefits beginning with January 1971 and for lump-sum death payments in the case of insured individuals who die after December 1970.

SECTION 105. ELECTION TO RECEIVE ACTUARIALY REDUCED BENEFITS IN ONE CATEGORY NOT TO BE APPLICABLE TO CERTAIN BENEFITS IN OTHER CATEGORIES

Section 105 of the bill eliminates the provision in present law under which a person who is eligible for both (1) an old-age insurance benefit and (2) a wife's or husband's insurance benefit and who files for either before age 65 is deemed to have filed for both. It also eliminates the provision in present law under which a person who gets a reduced benefit in one benefit category has any subsequent benefit he gets reduced to take account of the fact that he got the first benefit early.

Section 105(a)(1) of the bill amends section 202(q)(3)(A) of the Social Security Act to provide that the methods of figuring a reduction under section 202(q)(3)(B) (providing for reduced wife's or husband's benefits to take account of the receipt of an actuarially reduced old-age insurance benefit) or a reduction under section 202(q)(3)(C) (providing for reduced wife's, husband's, widow's, or widower's benefits to take account of the receipt of a reduced disability benefit) will only apply if they provide a higher benefit than would be payable if the receipt of the reduced old-age insurance benefit in section 202(q)(3)(B) or of the disability insurance benefit in section 202(q)(3)(C) were ignored. Present law will continue to be applied in cases where it would produce a higher benefit.

Section 105(a)(2) of the bill amends section 202(q)(3) of the act by striking out subparagraph (E) (providing for the reduction of an old-age insurance benefit to take account of the prior receipt of a reduced widow's or widower's benefit), subparagraph (F) (providing for the reduction in a disability benefit beginning with or after age 62 to take account of the receipt of a reduced widow's or widower's benefit), and subparagraph (G) (providing for a similar reduction in a disability benefit received before age 62). The effect of these changes is to eliminate the reduction in an old-age insurance benefit or a disability insurance benefit which would be made under present law to take account of receipt of reduced widow's or widower's benefits.

Section 105(b) of the bill repeals section 202(r) of the act, which provides that a person who is eligible in a given month for a benefit as a retired worker and as a spouse is deemed to have filed for both if he files for either.

Section 105(c)(1)(A) of the bill provides that (subject to the subsequent provisions of section 105) the amendments made by section 105(a) will be effective with respect to benefits for and after the sixth month after the month of enactment.

Section 105(c)(1)(B) of the bill provides that, in the case of a person who was on the rolls before the sixth month after the month of enactment, the amendments made by section 105(a) will be effective only if the person files a written request, which must take the form of a request for a redetermination of his benefit amount under section 105(c)(2) in the case of a person who is simultaneously entitled to two actuarially reduced benefits and who was deemed (or, except for the fact that an application was filed, would have been deemed) under section 202(r) of the act to have filed an application for the second such benefit; in the latter case the redetermination will apply unless the person who filed the request refuses to accept it. If the request is filed before the end of the sixth month after the month of enactment, the redetermination will be effective with respect to benefits for months beginning with such sixth month; if the request is not filed before the end of the sixth month after the month of enactment the redetermination will be effective with respect to benefits for and after the second month following the month in which the request is filed.

Section 105(c)(1)(C) of the bill provides that section 105(b) (eliminating the deemed filing provisions) will be effective on the basis of applications filed on or after the date of enactment of the bill.

Section 105(c)(2)(A) of the bill provides that where a person entitled to reduced benefits in the fifth month following the month of enact-

ment was deemed (or, except for the fact that an application was filed, would have been deemed) to have filed an application for benefits in another category, and files a written request for a redetermination, the Secretary will redetermine both benefits as though there had been no deemed filing requirement at the time the person applied for benefits.

Section 105(c)(2)(B) of the bill provides the method for redetermining benefits in cases where the person was deemed (or, except for the fact that he filed an application, would have been deemed) to have filed for one of the benefits. The smaller benefit is assumed to have been taken in the first month of the simultaneous entitlement. The larger benefit is assumed to have been taken in the month in which the redetermination is effective (or at age 65, if earlier). The amount of total benefits actually received prior to the effective month of the redetermination will be measured against the amount of total benefits which would have been received if the amendments had always been in effect. The excess of the former (if any) over the latter will be recovered to the extent and in the manner provided in section 105(c)(2)(C) and (E), discussed below.

Section 105(c)(2)(C) of the bill provides that an individual who requests a redetermination will be notified by the Secretary of the amount of the benefits as redetermined, the amount of the excess to be recovered, and the extent of the period over which recovery will be made. The individual will have 30 days after notification is mailed to reject the redetermination.

Section 105(c)(2)(D) of the bill provides that if the request for a redetermination is filed before the end of the sixth month following the month of enactment and the redetermination is not refused, it will be effective with respect to benefits for and after the sixth month after the month of enactment. If the request is filed after the sixth month after the month of enactment and the redetermination is not refused, it will be effective with respect to benefits for and after the second month after the month in which the redetermination is requested.

Section 105(c)(2)(E) of the bill provides that the Secretary will recover any excess in benefits paid to a person to which a redetermination applies only by withholding the amount of the monthly increase in such person's benefits resulting from the amendment, made by section 105 (a) and (b); the person can receive no less in total monthly benefits after the redetermination than he was receiving before the redetermination was effective. (If the beneficiary dies recovery will be considered complete, and no recovery will be made from any benefit that is not increased as a result of this section or these amendments).

Section 105(d) of the bill (a saving clause) prevents any reduction in benefits for other members of a family when benefits are increased under this section for someone getting benefits on the same earnings record.

SECTION 106. LIBERALIZATION OF EARNINGS TEST

Section 106(a) of the bill amends paragraphs (1), (3), and (4)(B) of section 203(f) of the Social Security Act to increase the amount of earnings a beneficiary may have in a year and still be paid full benefits for the year. It also makes a conforming amendment in paragraph (1)(A) of section 203(h) of the act, which requires beneficiaries to report if their earnings exceed the permissible amount in a year.

Paragraph (1) of the amended section 203(f) provides that, for purposes of the retirement test (the provision in the law under which some or all benefits are withheld when a beneficiary under age 72 has exceeded a specified amount of earnings), any earnings of a beneficiary in excess of the amount he may earn and still get full benefits for the year (the annual exempt amount) will not be charged to any month in which he did not engage in self-employment and render services for wages of more than \$166.66% (instead of \$140 as in present law). The effect of this change is that regardless of a beneficiary's total earnings in a year his benefits may not be withheld for any month in which he did not have wages of more than \$166.66% (and did not engage in self-employment).

Paragraph (3) of the amended section 203(f) provides that a person's "excess earnings" for any taxable year will be his earnings in excess of \$166.66% (instead of \$140 as in present law) times the number of months in his taxable year. The effect of this change is that a beneficiary will get benefit each month of a year if his earnings for the year do not exceed \$2,000 (instead of \$1,680 as under present law), and that the provision under which benefits are reduced by \$1 for each \$2 of the first \$1,200 of excess earnings will apply to earnings between \$2,000 and \$3,200 (instead of between \$1,680 and \$2,880).

Paragraph (4)(B) of the amended section 203(f) provides that in determining whether a beneficiary earned more in a month than \$166.66% (instead of \$140 as under present law) for purposes of applying the monthly exemption under paragraph (1) of such section, he will be presumed to have earned more than that amount until it is shown to the satisfaction of the Secretary that he did not do so.

Paragraph (1)(A) of the amended section 203(h) requires a beneficiary to report his earnings to the Secretary of Health, Education, and Welfare whenever he has excess earnings as defined in the amended section 203(f).

Section 106(b) of the bill provides that these amendments will be effective for taxable years ending after December 1970.

SECTION 107. EXCLUSION OF CERTAIN EARNINGS IN YEAR OF ATTAINING AGE 72

Section 107(a) of the bill amends section 203(f)(3) of the Social Security Act by adding a new clause (B) which provides that, in the year in which an individual attains age 72, earnings in and after the month in which he attains age 72 will not be counted in determining his excess earnings for such year.

Section 107(b) provides that this change will be effective for taxable years ending after December 1970.

SECTION 108. REDUCED BENEFITS FOR WIDOWERS AT AGE 60

Section 108 of the bill provides for actuarially reduced benefits for nondisabled widowers as early as age 60, as is now the case for widows. The benefit amount is to be reduced by 57/120 of 1 percent per month for each month the benefit is taken before age 65. (See section 103 of the bill explaining benefit amounts from age 62 to 65 as provided by the bill.) The benefit amount at age 65 will equal 100 percent of the

worker's primary insurance amount; at age 62 it will equal 82.9 percent and at age 60 it will equal 71.5 percent.

Section 108(a) of the bill amends section 202(f) of the Social Security Act to provide for widowers' benefits for nondisabled widowers at age 60 as is now the case for widows.

Section 108(b)(1) and section 108(b)(2) of the bill amend section 203(c) of the act to provide that the retirement test is inapplicable to widowers between age 60 and 65 only if they became entitled to benefits before age 60 (i.e., on the basis of a disability) rather than before age 62 as under present law. This makes the application of the retirement test to widowers consistent with its application to widows.

Section 108(b)(3) of the bill amends section 222(b)(1) of the act to provide for deductions from widowers' benefits for refusal to accept rehabilitation services when the widower has not attained age 60, rather than if he has not attained age 62 as under present law, reflecting the fact that under these amendments nondisabled widowers' benefits will be available as early as age 60.

Section 108(b)(4) of the bill amends section 222(d)(1)(D) of the act to provide for funding of rehabilitation services for widowers entitled before age 60, rather than age 62 as under present law, reflecting the fact that under these amendments nondisabled widowers' benefits will be available as early as age 60.

Section 108(b)(5) of the bill amends section 225 of the act to provide for the suspension of widowers' benefits before age 60, rather than before age 62 as under present law, where the Secretary of Health, Education, and Welfare has information indicating that the widower has ceased to be under a disability, reflecting the availability of nondisabled widowers' benefits as early as age 60.

Section 108(c) of the bill provides that these amendments will be effective for monthly benefits payable for months beginning with January 1971.

ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY WHICH BEGAN BETWEEN 18 AND 22

Section 109 of the bill provides child's insurance benefits to an otherwise qualified adult son or daughter if his disability has been continuous since before age 22 (rather than only if it was continuous since before age 18 as under present law).

Section 109(a) of the bill amends clause (ii) of section 202(d)(1)(B) of the Social Security Act to permit the payment of child's insurance benefits to an individual under a disability which began before he attained age 22 (rather than age 18).

Section 109(b) of the bill amends subparagraphs (F) and (G) of section 202(d)(1) of the act to provide that entitlement to child's insurance benefits will end, for a child who is over age 18 and disabled, with the second month following the month in which he ceases to be under a disability unless he is entitled as a full-time student under age 22.

Section 109(c) of the bill further amends section 202(d)(1) of the act by adding at the end a new sentence which provides that child's insurance benefits will not be payable to an individual in any month in which the individual engages in substantial gainful activity if his continuing entitlement to such benefits is solely by reason of disability as defined in section 223(d)(1)(B) of the act.

Section 109(d) of the bill amends subsection 202(d)(6) of the act to provide that (1) a child whose benefits are terminated at or after age 18 can be re-entitled to child's benefits if he is disabled (as defined in section 223(d) of the act) before age 22, and (2) such re-entitlement will end with the month preceding the month in which the child dies, marries, or (in certain cases) is adopted, or with the second month following the month disability ceases unless the child is entitled as a full-time student and has not attained age 22.

Section 109(e) of the bill makes two changes in section 202(s) of the act. Section 109(e)(1) amends paragraph (1) of section 202(s) to exclude persons entitled to child's insurance benefits by reason of becoming disabled after attaining age 18 but before age 22 from the category of children aged 18-21 whose mothers are ineligible for benefits on the basis of having entitled children aged 18-21 in their care. Section 109(e)(2) amends paragraph (2) of section 202(s) to extend to persons entitled to child's insurance benefits by reason of becoming disabled after attaining age 18 but before age 22 the provisions that permit a childhood disability beneficiary to continue to get benefits when he marries another beneficiary, and which permit such other beneficiary to continue to get benefits when he marries such childhood disability beneficiary. Section 109(e)(2) also amends paragraph (3) of section 202(s) to extend to the child entitled on the basis of a disability that began after age 18 but before age 22 (1) the exemption from the dependency requirements in present law for husband's and widower's benefits, (2) the provisions of existing law for terminating, in the case of a male childhood disability beneficiary, benefits payable to his spouse if his benefits as a disabled child terminate because he is no longer disabled, (3) the provisions of present law that exempt a disabled child from having his benefits withheld on account of work, and (4) the provisions of present law under which a disabled child can, upon marriage, become eligible as a wife, widow, husband, or widower beneficiary.

Section 109(f) of the bill (a saving clause) protects beneficiaries on the old-age, survivors, and disability insurance benefit rolls in December 1970 in certain cases where an individual is made eligible for benefits by this section of the bill. If an individual who is made eligible by this section becomes entitled to benefits for January 1971, then each member of the family who was entitled to benefits for December 1970 will get an amount no less than he would have gotten if the newly eligible person had not become entitled to benefits, in spite of the provisions of section 203(a) (relating to the limit on the total amount of benefits payable to a family). The benefit amount of the newly entitled person would be determined without regard to the saving clause.

Section 109(g) of the bill provides that these amendments will apply with respect to monthly benefits for months after December 1970, except that in the case of an individual who is not entitled to benefits under section 202 of the act for December 1970 they will apply only on the basis of an application filed after September 30, 1970.

SECTION 110. ELIMINATION OF SUPPORT REQUIREMENT AS CONDITION OF BENEFITS FOR DIVORCED AND SURVIVING DIVORCED MOTHERS

Section 110(a) of the bill amends section 202(b)(1) of the Social Security Act by removing the requirement that to get wife's benefits

an otherwise qualified divorced wife must have been receiving one-half of her support from her former husband or receiving substantial contributions from him pursuant to a written agreement unless there is a court order in effect for substantial contributions to her support from him.

Section 110(b)(1) of the bill amends section 202(e)(1) of the act by removing the requirement that to get widow's insurance benefits an otherwise qualified surviving divorced wife must have been receiving one-half of her support from her former husband or receiving substantial contributions from him pursuant to a written agreement unless there is a court order in effect for substantial contributions to her support from him.

Section 110(b)(2) of the bill makes a conforming change in section 202(e)(6) of the act.

Section 110(c) of the bill amends section 202(g)(1) of the act removing the requirement in subparagraph (F) that to get mother's insurance benefits an otherwise qualified surviving divorced mother must have been receiving one-half of her support from her former husband or receiving substantial contributions from him pursuant to a written agreement unless there is a court order in effect for substantial contributions to her support from him.

Section 110(d) of the bill makes these amendments effective for and after January 1971 on the basis of applications filed on and after the date of enactment of the bill.

ELIMINATION OF DISABILITY INSURED-STATUS REQUIREMENT OF SUBSTANTIAL RECENT COVERED WORK IN CASES OF INDIVIDUALS WHO ARE BLIND

Section 111 of the bill provides that a blind individual can be insured for disability insurance benefits and establish a period of disability (disability freeze) without meeting a requirement of substantial recent covered work. Under present law, to meet this requirement a disabled worker (including a blind worker) generally needs 20 quarters of coverage during the period of 40 calendar quarters ending with the quarter in which he became disabled. (An alternative provision takes into account that workers who are disabled while young may have been in the work force for a relatively short time.)

Section 111(a) of the bill amends section 216(i)(3) of the Social Security Act by excepting an individual whose disability is blindness (as defined in section 216(i)(1) of the act) from the requirement of substantial recent covered work for purposes of qualifying for a period of disability.

Section 111(b) of the bill amends section 223(c)(1) of the act by excepting an individual whose disability is blindness from the requirement of substantial recent covered work for purposes of qualifying for disability insurance benefits.

Section 111(c) of the bill provides that these amendments will be effective with respect to applications for disability insurance benefits, and for disability determinations for purposes of establishing a period of disability, that are filed in or after the month of enactment, or before such month if the applicant has not died before such month and if either (1) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been given before such month but a civil action thereon is com-

menced (whether before, in, or after such month) under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month; except that no monthly benefits would be payable or increased by reason of these amendments for months before January 1971.

SECTION 112. WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

Section 112(a) of the bill amends section 229(a) of the Social Security Act to provide noncontributory wage credits for service in the uniformed services of the United States after 1956 and before 1968. (The noncontributory wage credits are in addition to credits for the serviceman's covered wages, i.e., his basic service pay.) The amount of the noncontributory wage credits will be determined in the same way as noncontributory wage credits for years after 1967 are determined under present law. Ordinarily, this amount is \$300 for each calendar quarter in which the serviceman received covered wages on a contributory basis for his service, but it is limited to \$100 for any calendar quarter in which his service pay was \$100 or less, and \$200 for any calendar quarter in which his service pay was more than \$100 but not more than \$200. (As under present law, additional benefits paid as a result of these additional credits will be financed from general revenues.)

Section 112(b) of the bill provides that the amendments made by section 112(a) will apply with respect to monthly benefits payable under title II of the act for months after December 1970 and to lump-sum death payments in the case of deaths after December 1970. Any person on the benefit rolls in December 1970 whose monthly benefits can be increased as a result of the noncontributory wage credits provided under section 112(a) can have his benefits increased if he or any other person entitled to monthly benefits on the same earnings record files an application for a recomputation of benefits. The recomputed benefit amount will be effective for months beginning with January 1971, or, if later, the twelfth month before the month in which the application for a recomputation of benefits is filed. Recomputation of benefits to take into account the wage credits provided under section 112(a) will be made notwithstanding the limitations on recomputations contained in section 215(f)(1) of the act (in general, benefits cannot be recomputed unless there were earnings after 1965), and no such recomputation will be regarded as a recomputation for purposes of section 215(f).

APPLICATIONS FOR DISABILITY INSURANCE BENEFITS FILED AFTER DEATH OF INSURED INDIVIDUAL

Section 113 of the bill provides that a period of disability (disability freeze) can be established and disability insurance benefits (and related dependents' benefits) can be paid on the basis of an application filed within 3 months after the month of the death of the disabled individual.

Section 113(a)(1) of the bill amends section 223(a)(1) of the Social Security Act by adding at the end a new sentence which provides that entitlement to disability insurance benefits, in the case of a deceased individual, may be based upon an application filed within 3 months after the month in which he died.

Sections 113(a)(2), (3), and (4) of the bill make conforming changes in sections 223(a), (b), and (c) of the act.

Section 113(b) of the bill amends section 216(i)(2)(B) of the act by adding at the end a new sentence which provides that a period of disability may begin on the basis of an application for a disability determination filed with respect to a deceased individual within 3 months after the month in which he died.

Section 113(c) of the bill provides that these amendments will apply in cases of deaths occurring in and after the year of enactment. In addition it provides that where a death occurred prior to the date of enactment but in the year of enactment, an application filed in accordance with such amendments within 3 months after the date of enactment will, for purposes of sections 202(j)(1) (relating to the retroactive life of an application for dependents' benefits) and 223(b) (relating to the retroactive life of an application for disability insurance benefits) of the act, be deemed to have been filed in the month such death occurred.

WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

Section 114(a) of the bill amends paragraph (5) of section 224(a) of the Social Security Act to provide that, where workmen's compensation is payable, social security disability benefits will be reduced only by the amount by which the combined workmen's compensation and social security payments exceed 100 percent of the workers' average current earnings (as defined in section 224(a)) before he became disabled. (Under present law, the reduction applies to the amount exceeding 80 percent of such earnings.)

Section 114(b) of the bill provides that this amendment will apply with respect to monthly benefits for months after December 1970.

SECTION 115, COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

Section 115(a) of the bill provides social security coverage for service performed in the employ of a Federal Home Loan Bank. The Social Security Amendments of 1956 amended section 210(a)(6)(B)(ii) of the Social Security Act and section 3121(b)(6)(B)(ii) of the Internal Revenue Code of 1954 to provide such coverage subject to the condition that the Banks coordinate their retirement systems with social security and that the plan for coordination be submitted to and approved by the Secretary of Health, Education, and Welfare by July 1, 1957. This condition was not met, and service for Federal Home Loan Banks has never been covered for social security purposes. Under section 115(a), coverage is effective for all service performed in the employ of a Federal Home Loan Bank after December 1970, and, for persons in the employ of such a bank on January 1, 1971, is effective for service performed in the employ of such a Bank after December 1965 but only if both the employee and the employer contributions as specified in the Federal Insurance Contributions Act for all such persons are paid (as provided in section 3122 of such act) by July 1, 1971, or later if agreed to before such date by the banks and the Secretary of the Treasury or his delegate.

Section 115(b) of the bill repeals subparagraphs (A)(i) and (B) of section 104(i)(2) of the Social Security Amendments of 1956, which

contained the condition that the FHLB retirement systems must be coordinated with social security and approved by the Secretary of Health, Education, and Welfare by July 1, 1957.

SECTION 116. POLICEMEN AND FIREMEN IN IDAHO

Section 116 of the bill amends section 218(p)(1) of the Social Security Act to add the State of Idaho to the list of States specifically named in the law as States which may modify their section 218 agreement to provide coverage under the social security program for policemen and firemen who are in positions under a State or local retirement system. (Section 218(p)(2) of the Social Security Act, added by the Social Security Amendments of 1967, makes social security coverage available to firemen who are members of a retirement system in States not listed in section 218(p)(1), but only if special conditions are met.) The effective date of such coverage would be whatever date is specified by the State of Idaho in the modification of its agreement, but could not be earlier than the beginning of the fifth year before the year in which the coverage is arranged.

SECTION 117. COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

Section 117 of the bill permits the State of New Mexico, notwithstanding the provisions of section 218 of the Social Security Act, to modify its coverage agreement with the Secretary of Health, Education, and Welfare at any time before January 1, 1971, to provide coverage for services of employees of a hospital which is an integral part of a political subdivision to which the coverage agreement has not been made applicable. The employees of such hospital would be covered as a separate coverage group as defined in section 218(b)(5) of the act; and such coverage can apply only to service performed for a hospital which has, prior to 1966, withdrawn from a retirement system which had been applicable to the employees of such hospital.

SECTION 118. PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN A SOCIAL SECURITY ACCOUNT NUMBER

Section 118(a) of the bill amends section 208 of the Social Security Act by adding a new subsection (f) to provide that the penalties in present law for certain fraudulent representations to the Secretary of Health, Education, and Welfare will apply to an individual who willfully, knowingly, and with the intent of deceiving the Secretary as to his true identity (or the true identity of any other person) furnishes false information with respect to any information required by the Secretary in connection with the establishment and maintenance of the social security records of wages and self-employment income.

Section 118(b) of the bill provides that this amendment will apply in the case of information furnished to the Secretary after the date of enactment of the bill.

SECTION 119. GUARANTEE OF NO DECREASE IN TOTAL
FAMILY BENEFITS

Section 119(a) of the bill amends section 203(a) of the Social Security Act (as otherwise amended by the bill) to add a permanent saving clause to guarantee that when a worker is getting an actuarially reduced benefit and his primary insurance amount is increased, the total benefits payable to the family on his earnings record will not be decreased. In some such cases, if the benefits payable to a family are subject to the maximum limitation on the total amount of benefits payable on one earnings record, the family might, without such a saving clause, get less in total benefits after the worker's primary insurance amount is increased than they were getting before.

Section 119(b) makes permanent a special temporary saving clause provided by section 1002(b)(2) of the Social Security Amendments of 1969. Section 1002(b)(2) provided that where a person was on the benefit rolls in 1970 he, or his family, will never get less than he or they would have gotten prior to the 15-percent benefit increase provided by the 1969 amendments as long as the person on the rolls in 1970 remains on the rolls. Under the change, the no-loss guarantee will apply permanently; i.e., it will apply without regard to whether the person on the benefit rolls in 1970 remains on the rolls.

SECTION 120. INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX
PURPOSES

Section 120 of the bill raises the amount of annual earnings that is subject to social security contributions and counted toward social security benefits (the contribution and benefit base) from \$7,800 to \$9,000 beginning with 1971.

Amendments to Title II of the Social Security Act

Definition of wages

Section 120(a)(1) of the bill amends section 209(a) of the Social Security Act (defining "wages" for benefit purposes) to make the \$9,000 contribution and benefit base applicable to wages paid after 1970.

Definition of self-employment income

Section 120(a)(2) of the bill amends section 211(b)(1) of the act (defining "self-employment income" for benefit purposes) to make the \$9,000 contribution and benefit base applicable for taxable years beginning after 1970.

Quarter of coverage

Section 120(a)(3) of the bill amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining "quarter of coverage") to provide that an individual will be credited with a quarter of coverage for each quarter of a calendar year after 1970 in which his wages for such year equal \$9,000 (rather than \$7,800 as in present law). An individual will also be credited with a quarter of coverage for each quarter any part of which falls within a taxable year beginning after 1970 in which the sum of his wages and self-employment equals \$9,000.

Average monthly wage

Section 120(a)(4) of the bill amends section 215(e)(1) of the act (relating to the amount of annual earnings that can be counted in computing a person's average monthly wage) to increase from \$7,800 to \$9,000, effective for calendar years after 1970, the maximum amount of annual earnings that may be counted in the computation of a person's average monthly wage for purposes of determining benefit amounts.

*Amendments to the Internal Revenue Code of 1954**Definition of self-employment income*

Section 120(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining "self-employment income" for social security tax purposes) by increasing from \$7,800 to \$9,000 the amount of annual self-employment income subject to social security contributions for taxable years beginning after 1970.

Definition of wages

Section 120(b)(2) of the bill amends section 3121(a)(1) of the code (defining "wages" for social security tax purposes) by increasing from \$7,800 to \$9,000 the amount of annual wages subject to contributions for calendar years after 1970.

Federal service

Section 120(b)(3) of the bill amends section 3122 of the code (relating to Federal service) to conform its provisions to the increase in the contribution and benefit base from \$7,800 to \$9,000.

Returns in the case of certain governmental employees

Section 120(b)(4) of the bill amends section 3125 of the code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) to conform its provisions to the increase in the contribution and benefit base from \$7,800 to \$9,000.

Special refunds of employee contributions

Sections 120(b)(5) and 120(b)(6) of the bill amend section 6413(c) of the code (relating to special refunds of social security contributions paid by an employee who in any calendar year had more than one employer and had total wages in excess of the maximum which may be counted) to conform the special refund provisions to the \$9,000 contribution and benefit base for calendar years after 1970.

Estimated tax on self-employment income

Section 120(b)(7) of the bill amends section 6654(d)(2)(B)(ii) of the code (relating to failure to pay estimated income tax on adjusted self-employment income) to conform to the increase in the contribution and benefit base to \$9,000.

Effective dates

Section 120(c) provides effective dates for the changes made by the section. The amendments (relating to wages) made by sections 120(a)(1), 120(a)(3)(A), and 120(b) (except paragraphs (1) and (7) thereof) are applicable with respect to remuneration paid after December 1970; the amendments (relating to self-employment in-

come) made by sections 120(a)(2), 120(a)(3)(B), 120(b)(1) and 120(b)(7) are applicable with respect to taxable years beginning after 1970; and the amendment made by section 120(a)(4) (relating to average monthly wage) is applicable with respect to calendar years after 1970.

SECTION 121. CHANGES IN TAX SCHEDULES

Section 121 of the bill provides new schedules of social security tax rates for old-age, survivors, and disability insurance and for hospital insurance.

Old-age, survivors, and disability insurance rates

Section 121(a) of the bill amends sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954 to provide new schedules of old-age, survivors, and disability insurance tax rates for the self-employed and for employees and employers.

Subsection (a) of the amended section 1401 provides a new schedule of tax rates on self-employment income for purposes of old-age, survivors, and disability insurance. Under present law, these tax rates are as follows:

Taxable years beginning after:	Percent
1968 (and before 1971)-----	6. 3
1970 (and before 1973)-----	6. 9
1972-----	7. 0

Under the bill, the tax rates on self-employment income for old-age, survivors, and disability insurance are as follows:

Taxable years beginning after:	Percent
1968 (and before 1975)-----	6: 3
1974-----	7. 0

Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide new schedules of tax rates on wages for purposes of old-age, survivors, and disability insurance. Under present law, these tax rates for employees and employers are as follows:

Calendar years:	Percent
1969 to 1970, inclusive-----	4. 2
1971 to 1972, inclusive-----	4. 6
1973 and after-----	5. 0

Under the bill, the tax rates on wages for both employees and employers for old-age, survivors, and disability insurance are as follows:

Calendar years:	Percent
1969 to 1974, inclusive-----	4. 2
1975 to 1979, inclusive-----	5. 0
1980 and after-----	5. 5

Hospital insurance rates

Section 121(b) of the bill amends sections 1401(b), 3101(b), and 3111(b) of the code to provide new schedules of hospital insurance tax rates for the self-employed and for employees and employers.

Subsection (b) of the amended section 1401 provides a new schedule of tax rates on self-employment income for purposes of hospital insurance. Under present law, these tax rates are as follows:

Taxable years beginning after:	Percent
1967 (and before 1973).....	0.60
1972 (and before 1976).....	.65
1975 (and before 1980).....	.70
1979 (and before 1987).....	.80
1986.....	.90

Under the bill, the tax rates on self-employment income for hospital insurance are as follows:

Taxable years beginning after:	Percent
1967 (and before 1971).....	0.6
1970.....	1.0

Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide new schedules of tax rates on wages for purposes of hospital insurance. Under present law, these tax rates are as follows:

Calendar years:	Percent
1968 to 1972, inclusive.....	0.60
1973 to 1975, inclusive.....	.65
1976 to 1979, inclusive.....	.70
1980 to 1986, inclusive.....	.80
1987 and after.....	.90

Under the bill, the tax rates on wages for both employees and employers for hospital insurance are as follows:

Calendar years:	Percent
1968 to 1970, inclusive.....	0.6
1971 and after.....	1.0

Effective dates

Section 121(c) of the bill provides that the amendments made by sections 121(a)(1) and 121(b)(1) are to apply with respect to taxable years which begin after December 31, 1970, and that the remaining amendments made by section 121 are to apply with respect to remuneration paid after December 31, 1970.

SECTION 122. ALLOCATION TO DISABILITY INSURANCE TRUST FUND

Section 122(a) of the bill amends section 201(b)(1) of the Social Security Act, which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to wages and presently provides that such amount with respect to any wages paid after 1969 is to be 1.10 percent of such wages. Under the amended section 201(b)(1), the amount so allocated and appropriated will be 0.90 percent of the wages paid during 1971, 1972, 1973, and 1974, 1.05 percent of the wages paid during 1975, 1976, 1977, 1978, and 1979, and 1.15 percent of the wages paid after 1979.

Section 122(b) of the bill amends section 201(b)(2) of the act, which deals with the amount to be allocated and appropriated to the Federal Disability Insurance Trust Fund each year with respect to self-employment income and presently provides that the amount to be so allocated and appropriated with respect to any self-employment income reported for taxable years beginning after 1969 is to be 0.825 percent of the amount of such self-employment income. Under the amended section 201(b)(2), the amount so allocated and appropriated will be 0.675 percent of the self-employment income so re-

ported for any taxable year beginning after 1970 and before 1975, 0.7875 percent of the self-employment income so reported for any taxable year beginning after 1974 and before 1980, and 0.8625 percent of the self-employment income so reported for any taxable year beginning after 1979.

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

PART A—COVERAGE UNDER MEDICARE PROGRAM

SECTION 201. PAYMENT UNDER MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Section 201 of the bill amends section 1862 of the Social Security Act (relating to exclusions from coverage) by adding a new subsection (c) which provides that no payment may be made under either part A or part B of the medicare program for any item or service furnished to or on behalf of an individual on or after January 1, 1972, if such item or service is covered under a Federal employees health benefits plan in which the individual is enrolled, unless the Secretary has determined and certified prior to the date such item or service is furnished that the Federal employees health benefits program has been modified to assure that—

(1) there is available to each Federal employee or annuitant age 65 and over one or more health benefits plans which supplement the combined protection provided under parts A and B of title XVIII, and one or more health benefits plans which supplement the protection provided under part B alone; and

(2) the Government will make a contribution toward the cost of the supplementary protection which is at least equal to the contribution it makes for high option coverage under the Government-wide Federal employees health benefits plans; such contribution could be in the form of a contribution toward the supplementary protection, a payment to offset the cost of title XVIII coverage, or some combination of the two.

SECTION 202. HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER PRESENT TRANSITIONAL PROVISION

Section 202 of the bill substantially rewrites section 103 of the Social Security Amendments of 1965, which permits certain persons not entitled to social security or railroad retirement cash benefits to qualify for hospital insurance benefits, in order to permit additional uninsured individuals to qualify for such benefits.

Section 202(a) of the bill amends section 103(a) of the 1965 amendments to provide that, in addition to persons meeting the present requirements of such section, a person who (1) is a resident citizen or resident alien age 65 or over but not eligible for cash benefits, (2) does not otherwise qualify for hospital insurance coverage, (3) has filed an application for hospital insurance coverage under this section as required by regulations, and (4) has enrolled for supplementary medical insurance as provided in section 1837 of such Act as modified by the new section 103(d) (discussed below) will be entitled to benefits

under part A of title XVIII. Such entitlement will begin with the day on which such person's coverage period (as provided in the new section 103(d)) begins and will end with the month in which he dies or, if earlier, the month before the month in which he becomes entitled to hospital insurance benefits under section 226 or certifiable as a railroad retirement beneficiary. The amended section 103(a) limits the 12-month retroactivity of hospital insurance coverage provided for under such section 103(a) to those people who are eligible for hospital insurance coverage as a result of their meeting the section's regular requirements.

Section 202(b) of the bill amends section 103(b) of the 1965 amendments to provide that a Federal employee, previously excluded by paragraph (3) of such section 103(b), may enroll for hospital insurance benefits provided for under section 103(a)(2) (as amended by the bill), if he meets the eligibility requirements for enrolling for such coverage as provided in section 103(d)(1) (as amended by section 202(d) of the bill).

Section 202(c) of the bill limits the provisions of section 103(c) of the 1965 amendments to payments made with respect to people who are entitled to hospital insurance benefits under section 226 of the act solely by reason of the existing provisions of section 103(a) of such amendments (as redesignated section 103(a)(1) by the bill).

Section 202(d) of the bill amends section 103 of the 1965 amendments by adding a new subsection (d) to provide that a person meeting the preceding eligibility requirements (as provided in the new section 103(a)(2)) may enroll for the hospital insurance benefits provided under section 103(a).

The new section 103(d) makes the provisions of sections 1837, 1838, 1839, and 1840 of the Social Security Act (relating to enrollment, coverage, premium amount, and premium payment, respectively, under the supplementary medical insurance part of title XVIII of the act) applicable for purposes of hospital insurance coverage under the amended section 103 with the following modifications:

(1) section 1837(c) of the act (relating to supplementary medical insurance enrollment) is modified to provide that an initial general enrollment period is to begin the first day of the second month which begins after the date of enactment of the bill and is to end March 31, 1971, with this initial general enrollment period being open to people who meet the eligibility requirements of the new section 103(a)(2);

(2) section 1837(d) of the act is modified to provide that for people first meeting the eligibility requirements for enrolling for hospital insurance benefits provided in such section 103(a)(2) on or after March 31, 1971, there will be an initial enrollment period as otherwise provided in such section 1837(d);

(3) section 1838(a)(1) of the act (relating to supplementary medical insurance coverage period) is modified to provide that for people enrolling for hospital insurance benefits under the new section 103(d)(1) during the initial general enrollment period described above, the hospital insurance coverage period will begin January 1, 1971, or the first day of the month following the month of enrollment, whichever is the latest;

(4) section 1838(b) of the act is modified to provide that a person's coverage period for hospital insurance benefits under the

new section 103(a)(2) will terminate when he becomes entitled to hospital insurance benefits under the existing provisions of section 103(a) (as redesignated section 103(a)(1) by the bill), and that if a person's supplementary medical insurance enrollment is terminated his enrollment and coverage for hospital insurance under the new section 103(a)(2) will be terminated as of the same month his supplementary medical insurance enrollment and coverage terminate;

(5) section 1839(a) of the act is modified to provide that each person enrolling for hospital insurance benefits as provided under the new section 103(a)(2) will pay a \$27 monthly premium for each month he is covered for such hospital benefits before July 1972;

(6) section 1839(b)(1) of the act (relating to premium amounts) is modified to provide that the premium amount to be paid by each enrollee for each month after June 1972 will be an amount (as determined and promulgated by the Secretary in December of the preceding year, and rounded to the nearest \$1) equal to \$27 multiplied by the ratio of (1) the inpatient hospital deductible for the current year, as promulgated under section 1813(b)(2) of the act, to (2) such deductible promulgated for 1971; and

(7) section 1840 of the act is modified by substituting "Federal Hospital Insurance Trust Fund" for "Federal Supplementary Medical Insurance Trust Fund".

Section 202(d) of the bill further amends section 103 of the 1965 amendments by adding a new subsection (e) to provide that a State or any other public or private agency or organization will be permitted to pay monthly premiums on behalf of retired age-65-and-over employees who are eligible for and have enrolled for the hospital insurance protection provided by the new section 103(a)(2). Such group premium payment will be under a contract or other arrangement entered into between the agency or organization and the Secretary, and will be permitted only where the Secretary determines that such a method of premium payments is administratively feasible.

PART B—IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

SECTION 221. LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

Section 221(a) of the bill adds a new section 1122 at the end of title XI of the Social Security Act.

Subsection (a) of the new section 1122 expresses the congressional intent that funds appropriated under titles V, XVIII, and XIX of the act should not be used to support unnecessary capital expenditures and that reimbursement under such titles should support State health planning activities.

Subsection (b) of the new section 1122 provides that the Secretary, after consultation with the State executive officer and local public officials, is to make an agreement with any State under which a designated planning agency (which has a governing body or advisory body at least one-half of whose members represent consumer interests)

will (1) make findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility in its jurisdiction, (2) receive the findings and recommendations of other qualified planning agencies with respect to proposed capital expenditures of health care facilities in their jurisdiction, and (3) submit to the Secretary any such finding which indicates that any such expenditure is inconsistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans.

Subsection (c) of the new section 1122 provides that the Secretary will pay from the Federal Hospital Insurance Trust Fund to any State with which he makes an agreement the reasonable costs incurred by the planning agencies involved in preparing and forwarding findings and recommendations with respect to proposed capital expenditures.

Subsection (d)(1) of the new section 1122 provides that in determining reimbursement under titles V, XVIII, and XIX of the act the Secretary will disallow, for such periods as he finds necessary, expenses with respect to capital expenditures which are attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure if he determines (A) that neither the designated planning agency nor any other qualified planning agency had been notified of the proposed capital expenditure at least 60 days before it was made, or (B) that the agency had given notice to the facility within a reasonable period of time after receipt of notice of the proposed expenditure and prior to such expenditure that it would not be in conformity with the standards, criteria, or plans developed by such agency or any other qualified planning agency for adequate health care facilities in such jurisdiction, and prior to reporting its findings to the Secretary had consulted and taken into consideration the findings and recommendations of other planning agencies or organizations performing similar functions with respect to the area in which the health facility is located.

Subsection (d)(2) of the new section 1122 provides that if after submitting the matter to the national advisory council (discussed below) the Secretary determines that disallowance of any expense relating to a capital expenditure would be inconsistent with effective organization and delivery of health services or effective administration of title V, XVIII, or XIX, he shall not disallow such expense.

Subsection (e) of the new section 1122 provides that in determining reimbursement under titles V, XVIII, and XIX in cases where facilities or equipment are obtained under lease that would have been subject to a disallowance if purchased, the Secretary shall deduct from the facility's rental expenses an amount reasonably equivalent to that which would have been disallowed if the facilities or equipment had been purchased.

Subsection (f) of the new section 1122 provides that any person dissatisfied with a determination under the section may request reconsideration by the Secretary up to 6 months after notification; such determinations are not subject to other administrative or judicial review.

Subsection (g) of the new section 1122 defines the term "capital expenditure" as an expenditure which, under generally accepted

accounting principles, is not properly chargeable as an expense of operation and maintenance and exceeds \$100,000, changes the facility's bed capacity, or substantially changes the facility's services.

Subsection (h) of the new section 1122 provides that the section is not applicable to Christian Science sanatoriums.

Subsection (i)(1) of the new section 1122 directs the Secretary to establish or designate a national advisory council to assist and advise him in the preparation of regulations and on policy matters in the administration of the section.

Subsection (i)(2) of the new section 1122 provides that any council so established or designated is to consult and coordinate its activities with other appropriate national advisory councils and coordinate the activities under the section with related Federal health programs.

Subsection (i)(3) of the new section 1122 provides that if an advisory council is newly established by the Secretary its members are not to be in the regular full-time employ of the United States and are to be chosen from among leaders in the fundamental sciences, the medical sciences, or the organization, delivery, and financing of health care, or from among persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council will be entitled to compensation at rates to be determined by the Secretary but not to exceed the maximum rate paid to a GS-18.

Section 221(b) of the bill provides that the amendment made by section 221(a) will apply with respect to capital expenditures the obligation for which is incurred after June 30, 1971, or (with respect to any State or part thereof) earlier if the State so requests.

Section 221(c) of the bill amends various provisions of titles V, XVIII, and XIX of the act to make conforming changes and to require that standards applied under those provisions be consistent with the new section 1122.

SECTION 222. REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

Section 222(a)(1) of the bill authorizes the Secretary of Health, Education, and Welfare to develop and engage in experiments and demonstration projects designed to determine the advantages and disadvantages of various alternative methods of prospective reimbursement to hospitals, extended care facilities, and other providers of services under title XVIII of the act and under State plans approved under titles XIX and V of the act in order to stimulate providers through financial incentives to use their facilities and personnel more efficiently and thereby reduce program costs.

Section 222(a)(2) of the bill provides that such experiments and demonstration projects are to be of sufficient scope and applicability to permit evaluation of alternative methods of prospective reimbursement without committing the programs involved to the adoption of any prospective payment system either locally or nationally.

Section 222(a)(3) of the bill provides that the Secretary may waive payment requirements of titles V, XVIII, and XIX with respect to such experiments and demonstration projects. Any costs incurred in such experiments or projects in excess of amounts which would

normally be paid under such titles will be borne by the Secretary. The Secretary will obtain the advice and recommendations of competent specialists prior to instituting any such experiment or project, and will furnish to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least 60 days prior to placing an experiment or project in operation a written report containing a full description of the experiment or project.

Section 222(a)(4) of the bill provides that grants and payments for experiments and demonstration projects are to be made from the Federal trust funds established for the hospital and supplementary medical insurance programs under title XVIII of the act.

Section 222(a)(5) of the bill provides that the Secretary is to submit a report to the Congress no later than July 1, 1972, on the experiments and projects carried out. Such report is to include detailed recommendations with respect to program-wide implementation of a system of prospective reimbursement.

Section 222(a)(6) of the bill amends section 1875(b) of the Social Security Act to provide that the Secretary's annual report to the Congress concerning the operation of the health insurance program will include a report of the experiments and demonstration projects authorized by section 222(a).

Section 222(b)(1) of the bill amends section 402(a) of the Social Security Amendments of 1967 to provide authorization for the Secretary to develop and engage in experiments and demonstration projects for the following purposes: to determine whether changes in methods of payment (other than those authorized in section 222(a) of the bill) would create incentives for increasing efficiency and economy for health care and services under health programs established by the Social Security Act; to determine whether payments to organizations and institutions providing comprehensive health care services for noncovered services incidental to covered services would result in a more economical provision and effective utilization of covered services; to determine whether use of rates of payment approved by a State for purposes of administering one or more of its laws would reduce the costs of health programs established by the act; to determine whether payments based on a single, combined rate of reimbursement for teaching activities and patient care rendered by residents, interns, and supervisory physicians connected with a graduate medical education program would result in more equitable and economical patient care arrangements; and to determine whether areawide or community-wide utilization review and medical review mechanisms would more effectively control use of services. Grants and payments for these experiments and demonstration projects are to be made from the Federal trust funds established for the hospital and supplementary medical insurance programs under title XVIII of the act.

Section 222(b)(2) of the bill amends section 402(b) of the 1967 amendments to make conforming changes which permit demonstration projects as well as experiments and to require the Secretary to furnish to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate at least 60 days prior to placing an experiment or project in operation a written report containing a full description of the experiment or project.

Section 222(b)(3) of the bill amends section 1875(b) of the act to provide that the Secretary's annual report to the Congress concerning the operation of the health insurance program will include a report on the experiments and demonstration projects authorized under the amendments made by section 222(b) of the bill.

SECTION 223. LIMITATIONS ON COVERAGE OF COSTS UNDER MEDICARE PROGRAM

Section 223(a) of the bill amends section 1861(v)(1) of the act (defining reasonable cost for purposes of provider reimbursement) by excluding from recognition as reasonable any part of incurred cost found to be unnecessary in the efficient delivery of needed health services.

Section 223(b) of the bill amends section 1861(v)(1) of the act to provide for the establishment of limits on costs which will be recognized as reasonable based on estimates of the costs necessary in efficient delivery of services.

Section 223(c) and section 223(d) of the bill further amend section 1861(v)(1) of the act to make it clear that the medicare objective of meeting all direct and indirect costs of providing covered services to covered individuals does not extend to those costs determined to be unnecessary in the efficient delivery of covered services.

Section 223(e) of the bill amends section 1866(a)(2)(B) of the act to permit a provider to impose charges for items or services in excess of or more expensive than items or services for which reimbursement may be made under title XVIII even where not requested by the patient provided that (A) such charges are customarily imposed by such provider, do not exceed the excess cost of such items or services in the provider's previous fiscal period, and are identified (to the person to whom the items or services are furnished) as costs in excess of those determined to be necessary, and (B) the Secretary provides public notice that such charges may be imposed.

Section 223(f) of the bill amends section 1861(v) of the act (as otherwise amended by the bill) to provide for reduction of program reimbursement to providers of services in those instances where the provider imposes charges in excess of or more expensive than those determined to be necessary in the efficient delivery of health services to the extent that such charges exceed the cost actually incurred for such items or services.

Section 223(g) of the bill amends section 1866(a)(2) of the act to provide that a provider of services may not impose additional charges upon a patient as otherwise permitted under the amendments made by section 223 if the admitting physician has a direct or indirect financial interest in such provider.

Section 223(h) of the bill provides that these amendments will be effective upon the enactment of the bill.

SECTION 224. LIMITS ON PREVAILING CHARGE LEVELS

Section 224(a) of the bill amends section 1842(b)(3) of the Social Security Act with respect to the determination of the reasonable charge for services furnished under the supplementary medical insurance program. Under the amendment, no charge for services

rendered after June 30, 1970, and before July 1, 1971, may be determined to be reasonable if it exceeds the higher of (1) the prevailing charge recognized by the carrier for similar services in the same locality in administering the supplementary medical insurance program under part B of title XVIII on June 30, 1970, or (2) the prevailing charge level that would cover 75 percent of the customary charges made for similar services in the same locality during the calendar year 1969 on the basis of statistical data and methodology acceptable to the Secretary.

With respect to services rendered after June 30, 1971, the charges recognized as prevailing within a locality may be increased in any fiscal year only to the extent found necessary to cover 75 percent of the customary charges made for similar services in the same locality during the last preceding elapsed calendar year, on the basis of statistical data and methodology acceptable to the Secretary; in no case may they be increased (in the aggregate) beyond the levels that would cover 75 percent of the customary charges made for similar services in the same locality during the calendar year 1969, except to the extent that the Secretary finds that such adjustments are justified by economic changes on the basis of appropriate economic index data.

In the case of medical services, supplies, and equipment that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after June 30, 1970, and determined to be reasonable may exceed the lowest charge levels at which such services, supplies, and equipment are widely available in a locality only to the extent and under the circumstances specified by the Secretary.

Section 224(b) of the bill amends section 1903 of the act by adding a new subsection (g) providing that payment to States under the medicaid program may not be made with respect to any amount paid for items or services furnished under a State plan after June 30, 1970, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the amendments made by section 224(a) of the bill.

Section 224(c) of the bill amends section 506 of the act by adding a new subsection (f) providing that payment to States under the maternal and child health program may not be made with respect to any amount paid for items or services furnished under a State plan after June 30, 1970, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the amendments made by section 224(a) of the bill.

SECTION 225. ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE OUTPATIENT CARE UNDER MEDICAID PROGRAMS

Section 225(a) of the bill amends section 1903 of the Social Security Act (as otherwise amended by the bill) by adding a new subsection (e) to provide variable Federal matching rates for certain services provided under State medicaid plans. Under the amendment, with respect to services provided after December 1970 there will be (1) an increase of 25 percent in the matching rate (up to a maximum of 95 percent) for outpatient hospital services, clinic services, and home health services (other than physical therapy services); (2) a decrease of 33½ percent in the matching rate after the first 60 days of inpatient

hospital services furnished an individual in any fiscal year in a general or tuberculosis hospital; (3) a decrease of 33½ percent in the matching rate after the first 90 days of a patient's care in any fiscal year in a skilled nursing home; and (4) a decrease of 33½ percent in the matching rate after 90 days of a patient's care (occurring after December 1970) in a mental hospital, with the complete elimination of Federal matching after the patient has received an additional 275 days of such care during his lifetime.

Section 225(b)(1) of the bill amends section 1121 of the act by adding a new subsection (f), providing the Secretary with authority to reduce the amount of expenditures for which Federal matching will be available in the case of intermediate care facilities in a State (for calendar quarters after 1970), where he determines that a reasonable cost differential does not exist between the cost of skilled nursing home services and the cost of intermediate care facility services in such State, by the reasonable equivalent of the increased amount paid because of the lack of such differential.

Section 225(b)(2) of the bill amends section 1121(e) of the act to eliminate public mental institutions from the definition of "intermediate care facility".

SECTION 226. PAYMENT FOR SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE PROGRAM

Section 226 of the bill amends section 1833 of the Social Security Act with respect to the basis and amount of reimbursement for certain services performed by physicians in hospitals.

Section 226(a)(1) of the bill adds to section 1833(a)(1) of the act a new clause (C) describing two circumstances under which payment for services performed by a physician in a hospital and covered under the supplementary medical insurance program established under part B of title XVIII will be equal to 100 percent of the reasonable cost of the services to the hospital or other medical service organization which incurs the costs (instead of 80 percent of the charges for the services as in present law). Such payment on a reasonable cost basis will be applicable with respect to the physician's services to hospital patients if (1) the services are similar to services furnished in comparable circumstances to all patients (or all members of a class of patients) who are not covered under the insurance program under part B of title XVIII or under medicaid and such patients are not required to pay the reasonable charge for the services even when they have private insurance covering the services or (as defined in regulations) are otherwise able to pay, or (2) patients covered under part B of title XVIII are not required to pay any charges for the services, or are required to pay reasonable charges but without obtaining from them or on their behalf the applicable deductible and coinsurance amounts in addition to the part B payments.

Section 226(a)(2) of the bill adds to section 1833(d) of the act a new clause (3) to provide that expenses incurred under the supplementary medical insurance program for physicians' services which are reimbursed on the basis of 100 percent of reasonable cost to the hospital or medical service organization incurring such cost will not be taken into account for purposes of meeting the annual \$50 deductible under that program.

Section 226(b) of the bill provides that where the faculty of a medical school provides services in a hospital which would be reimbursable under part A of title XVIII if furnished directly by the hospital and the hospital pays to the medical school on account of such services less than the reasonable cost of such services to the school, the reasonable cost of such services to the medical school will be included in determining the reasonable cost to the hospital of furnishing services covered under part A.

Section 226(c) of the bill provides that the amendments made by section 226 (a) will apply to bills submitted and requests for payment made after the date of enactment of the bill, and that the amendments made by section 226(b) will be effective for accounting periods beginning after such date.

SECTION 227. AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

Section 227(a) of the bill amends section 1862 of the Social Security Act (as otherwise amended by the bill) by adding a new subsection (d) which provides that no payment may be made under either part A or part B of title XVIII for items or services furnished by a person whom the Secretary determines (1) has made or caused to be made false statements or misrepresentations of fact for use in applying for payment or determining the right to a payment under the medicare program; (2) has submitted or caused to be submitted bills or requests for payment containing charges (or costs) which the Secretary, with the concurrence of the program review team (discussed below), finds to be substantially in excess of such person's customary charges (or costs) unless there is good cause for such charges (or costs); or (3) has furnished services or supplies which the Secretary, with the concurrence of the physicians or other professional health personnel of the program review team, determines are substantially in excess of the needs of or are harmful to individuals, or are of grossly inferior quality. The determinations of the Secretary pursuant to these provisions are to be effective after there has been given such reasonable notice to the public and the person involved as may be specified in regulations. The stoppage of payment is to be effective with respect to services furnished on or after the effective date of the determination (except in the case of a hospital, extended care facility, and home health agency, for which the determination may be effective in the manner provided for terminations of agreements under section 1866(b) (3) and (4)) and will continue until the Secretary finds that the abuses which led to the decision have ceased and there is reasonable assurance that they will not recur. Any person furnishing services who is dissatisfied with the Secretary's decision is entitled to a hearing by the Secretary and to judicial review of the Secretary's decision.

The new section 1862(d) also provides for the establishment by the Secretary, in each State, of one or more program review teams. In appointing these teams the Secretary will consult with State and local professional societies, carriers and intermediaries, and consumer representatives. The duties of the teams will include (1) the review of statistical data on program utilization furnished by the Secretary; (2) the submission of periodic reports to the Secretary concerning this review together with any recommendations they may have concerning

it; (3) the review of particular cases where there is a likelihood of abuse; and (4) the submission to the Secretary of periodic reports concerning such review, together with their analyses and recommendations.

Section 227(b) of the bill amends section 1866(b)(2) of the act to provide that the Secretary may terminate an agreement with a provider of services under the medicare program if he determines that the provider (1) has made or caused to be made false statements or misrepresentations of fact for use in applying for payment or determining the right to a payment under that program; (2) has submitted or caused to be submitted requests for payment for services which are substantially in excess of the costs incurred in rendering such services; or (3) has furnished services or supplies which the Secretary, with the concurrence of the physicians or other professional health personnel of the program review team, determines are substantially in excess of the needs of or are harmful to individuals, or are of grossly inferior quality.

Section 227(c) of the bill amends section 1903(g) of the act (as added by section 224(b) of the bill) to provide that no payment may be made by the Federal Government to a State for amounts paid for items or services furnished after June 1970 under a State plan for medical assistance which are (1) in excess of the reasonable charge as determined under the third, fourth, and fifth sentences of section 1842(b)(3) (as added by the bill), or (2) precluded from payment under title XVIII because of a determination of the Secretary pursuant to the new section 1862(d)(1) or under the new clause (D), (E), or (F) of section 1866(b)(2).

Section 227(d) of the bill amends section 506(f) of the act to provide that no payment may be made by the Federal Government to a State for amounts paid for items or services furnished under a State plan for maternal and child health services and services for crippled children which are (1) in excess of the reasonable charge as determined under the third, fourth, and fifth sentences of section 1842(b)(3) (as added by the bill), or (2) precluded from payment under title XVIII because of a determination by the Secretary pursuant to the new section 1862(d)(1) or under the new clause (D), (E), or (F) of section 1866(b)(2).

SECTION 228. ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

Section 228 of the bill repeals section 1903(e) of the Social Security Act (and section 2(b) of Public Law 91-36) so as to remove the requirement that each State make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards".

SECTION 229. DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

Section 229(a) of the bill amends section 1902(a)(13) of the Social Security Act to authorize States to develop their own methods and standards for determining the reasonable cost of inpatient hospital care for medicaid eligibles, subject to the condition that (1) hospitals and private patients may not be required to bear the cost of care for those under the plan nor may the plan be required to pay for services to those not covered by the plan, and (2) reimbursement by the States may in no case exceed the amount which would be determined to be the reasonable cost of the inpatient hospital services under title XVIII.

Section 229(b) of the bill amends section 505(a)(6) of the act to give States the same authority (to develop their own methods and standards for determining the reasonable cost of inpatient hospital care, subject to the specified conditions) under their maternal and child health plans.

Section 229(c) provides that these amendments will be effective July 1, 1971 (or earlier if the State plan so provides).

SECTION 230. AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

Section 230(a) of the bill amends section 1814(b) of the Social Security Act to provide that payments to nonpublic providers of services under the hospital insurance program will, subject to the applicable deductible and coinsurance provisions, be the lesser of the reasonable cost of the services as determined under section 1861(v) of the act or the customary charges for the services. If the services are furnished free or at only nominal charge by a public provider of services, such payments will be determined on the basis of those items (specified in regulations) included in the determination of the reasonable cost which the Secretary finds will provide fair compensation for the services.

Section 230(b) of the bill amends section 1833(a)(2) of the act to provide that payments under the medical insurance program to nonpublic providers of services will be 80 percent of the lesser of the reasonable cost of the services as determined under section 1861(v) or the customary charges for the services. Public providers which furnish services free or at nominal charge will be reimbursed at 80 percent of reasonable cost as determined under section 1814(b)(2) of the act.

Section 1833(c) of the bill amends section 1903(g) of the act (as otherwise amended by the bill) to provide a similar basis for payments to States under their plans established and approved under title XIX of the act.

Sections 230(d) and 230(e) of the bill amend section 506(f) and section 509(a) of the act (as otherwise amended by the bill) to provide a similar basis for payments to States for items and services reimbursable under title V of the act.

Section 230(f) of the bill provides that the amendments made by section 230 (a) and (b) will apply to services furnished by hospitals, extended care facilities, and home health agencies in accounting pe-

riods beginning after June 30, 1970, and that the amendments made by section 230 (c), (d), and (e) will apply to services furnished in calendar quarters beginning after June 30, 1970.

SECTION 231. INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

Section 231(a) of the bill amends section 1861(e) of the Social Security Act to require an institution to have in effect an overall plan and budget in order to qualify as a hospital under the medicare program.

Section 231(b) of the bill amends section 1861(f)(2) of the act to impose a similar requirement with respect to psychiatric hospitals.

Section 231(c) of the bill amends section 1861(g)(2) of the act to impose a similar requirement with respect to tuberculosis hospitals.

Section 231(d) of the bill amends section 1861(j) of the act to impose a similar requirement with respect to extended care facilities.

Section 231(e) of the bill amends section 1861(o) of the act to impose a similar requirement with respect to home health agencies.

Section 231(f) of the bill further amends section 1861 of the act by adding a new subsection (z), which defines an overall plan and budget as one that provides for a detailed annual operating budget, provides for a capital expenditure plan for at least a 3-year period which includes all anticipated capital expenditures in excess of \$100,000, is reviewed and updated annually, and is prepared by a committee consisting of representatives of the administrative staff, the medical staff, and the governing body of the institution involved.

Section 231(g) of the bill amends sections 1814(a)(2)(C), 1814(a)(2)(D), and 1863 of the act to make conforming changes.

Section 231(h) of the bill amends section 1865 of the act to provide that if the Joint Commission on Accreditation of Hospitals requires hospitals to have institutional plans as defined in the new section 1861(z) as a condition of accreditation, all hospitals accredited by the Commission may be considered as satisfying the new section 1861(e)(8).

Section 231(i) of the bill provides that these amendments will apply with respect to any provider of services for its fiscal years beginning after the fifth month following the month in which this act is enacted.

SECTION 232. PAYMENTS TO STATES UNDER MEDICAID PROGRAMS FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Section 232(a) of the bill amends section 1903(a) of the Social Security Act by inserting a new paragraph (3) which authorizes 90-percent Federal matching to enable States to design, develop, and install mechanized claims processing and information retrieval systems deemed necessary by the Secretary to provide efficient and economical administration of their medicaid plans and to be compatible with claims processing and retrieval systems utilized in the administration of title XVIII, including matching of the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and that of any other State approved under title XIX.

The new section 1903(a)(3) also authorizes 75-percent Federal matching of administrative expenses incurred in the operation of such systems if they are approved by the Secretary and have the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers furnishing services to such recipients, the dates on which such services were furnished, and the amount of the payment made.

Section 232(b) of the bill provides that this amendment will apply to medicaid expenditures made after June 30, 1970.

SECTION 233. ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE PROGRAM

Section 233(a) of the bill amends section 1862 of the Social Security Act (as otherwise amended by the bill) by adding a new subsection (e). Paragraph (1) of the new subsection (e) provides that (1) where a patient's physician completes the certification for post-hospital extended care services or post-hospital home health services (which is required by subpar. (C) or (D) of sec. 1814(a)(2) of the act) for a condition which is designated in regulations, and (2) such physician submits to the extended care facility prior to the patient's admission a plan for furnishing the services or to the home health agency prior to the first visit a plan specifying the type and frequency of the services required, and (3) there is compliance with such additional procedures and requirements as may be prescribed in regulations, then the provisions of section 1862(a)(1) (excluding coverage for services which are not reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member) and section 1862(a)(9) (excluding coverage for custodial care) will not apply for the conditions and related periods of time prescribed in regulations. An exception to this rule is made where, in the case of extended care services, a finding is made by the facility's utilization review committee (under sec. 1814(a)(7) of the act) that further stay in the facility is not medically necessary.

Paragraph (2) of the new section 1862(e) provides that, in specifying the conditions and periods of time described above, the Secretary will take into account the medical severity of such conditions, the periods for which such conditions generally require extended care or home health services, the length of stay in an institution generally needed for treatment, and other pertinent factors affecting the type of care to be provided.

Paragraph (3) of the new section 1862(e) provides that if the Secretary determines that a physician is submitting with some frequency erroneous certifications of conditions prescribed in regulations or inappropriate plans of treatment, the provisions of sections 1862(a)(1) and 1862(a)(9) of the act will, after the date of such determination, apply to patients for whom such physician submits certifications or plans notwithstanding paragraph (1) of the new section 1862(e).

Section 233(b) provides that this amendment will be effective with respect to admissions to extended care facilities, and home health plans initiated, on and after January 1, 1971.

SECTION 234. PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO
BENEFITS

Section 234(a) of the bill amends section 1842(b) of the Social Security Act so as to prohibit payment for services provided under the supplementary medical insurance program to anyone other than the individual to whom the services were provided or the physician or other person providing the services. However, payment may be made to the employer of the physician or other person providing the services if such physician or other person is required as a condition of his employment to turn over his fee for such services to his employer; and where the service is provided in a hospital, clinic, or other facility payment may be made to the facility if there is a contractual arrangement between the physician or other person and the facility under which the facility submits the bill for such services.

Section 234(b) amends section 1902(a) of the act so as to prohibit payment for services provided under approved State medicaid programs to anyone other than the physician, dentist, or other independent practitioner who provided the services. However, payment may be made to the employer of such physician, dentist, or other independent practitioner if he is required as a condition of his employment to turn over his fees to the employer; and where the care or service to turn over his fee for such services to the employer; and where the care or service is provided in a hospital, clinic, or other facility payment may be made to the facility if there is a contractual arrangement between the practitioner and the facility under which the facility submits the bill for such services.

Section 234(c) of the bill provides that the amendment made by section 234(a) will apply with respect to bills submitted and requests for payment made after the date of enactment of the bill, and that the amendment made by section 234(b) will be effective July 1, 1971, or earlier if the State plan so provides.

SECTION 235. UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND
SKILLED NURSING HOMES UNDER MEDICAID AND MATERNAL AND
CHILD HEALTH PROGRAMS

Section 235(a)(1) of the bill amends section 1903(g) of the Social Security Act (as added and otherwise amended by the bill) to require as a condition of payment under the medicaid program that hospitals and skilled nursing homes participating in such program have their medicaid cases reviewed by the same utilization review committee which already reviews their medicare cases or, if such a committee does not exist, by a committee which meets the requirements imposed by section 1861(k) of the act for purposes of the medicare program.

Section 235(a)(2) of the bill amends section 1902(a)(30) of the act to make a conforming change.

Section 235(b) of the bill amends section 506(f) of the act (as added and otherwise amended by the bill) to impose with respect to services provided by hospitals and skilled nursing homes under the maternal and child health program (title V of the act) the same utilization review requirement as is imposed with respect to services under the medicaid program under the amendment made by section 235(a)(1).

Section 235(c) of the bill provides that the amendments made by section 235(a)(1) and (b) will apply to services furnished after June 30, 1971, and that the amendment made by section 235(a)(2) will be effective July 1, 1971.

SECTION 236. ELIMINATION OF REQUIREMENT THAT COST-SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOME

Section 236(a) of the bill amends section 1902(a)(14) of the Social Security Act to eliminate the requirement that any deductible or cost-sharing charge which is imposed under a State medicaid plan upon a medically indigent recipient must be related to such recipient's income or his income and resources. (The imposition of deductibles or cost-sharing charges upon cash assistance recipients continues to be prohibited.)

Section 236(b) of the bill provides that this amendment will be effective January 1, 1971 (or earlier if the State plan so provides).

SECTION 237. NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE PROGRAM

Section 237(a) of the bill amends section 1814(a)(7) of the Social Security Act to include among the cases where medicare payments are to be terminated for medically unnecessary services those cases where the services involved are found to be medically unnecessary by a utilization review committee or group in the course of its sample or other review of admissions to a hospital or extended care facility.

Section 237(b) of the bill provides that this amendment will be effective with respect to services furnished after the second month following the month in which the bill is enacted.

SECTION 238. USE OF STATE HEALTH AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

Section 238(a) of the bill amends section 1902(a)(9) of the Social Security Act to require State medicaid plans to provide that the State health agency will have responsibility for establishing and maintaining health standards for institutions in which medicaid recipients may receive care or services (with the State authority or authorities presently referred to in sec. 1902(a)(9) retaining responsibility for establishing and maintaining standards other than those relating to health for such institutions).

Section 238(b) of the bill amends section 1902(a) of the act by adding (in a new par. (32)) a new plan requirement under which the State health agency is given responsibility for establishing a plan for the review by professional health personnel of the quality and appropriateness of care and services furnished to medicaid recipients in order to provide guidance to the State medicaid agency, and (in most cases) is given responsibility for determining whether institutions and agencies meet the applicable requirements for participation in the medicaid program.

Section 238(c) of the bill amends section 505(a) of the act by adding (in a new par. (15)) substantially the same new plan require-

ment for maternal and child health purposes as the requirement added for medicaid purposes by section 238(b).

Section 238(d) of the bill provides that these amendments will be effective July 1, 1971.

SECTION 239. PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Section 239 (a) of the bill adds to title XVIII of the Social Security Act a new section 1876 providing for payments to health maintenance organizations.

Paragraph (1) of the new section 1876(a) authorizes the Secretary to determine by actuarial methods a combined part A and B prospective per capita rate of payment to health maintenance organizations. Payments are to be made for services provided to individuals who are enrolled in such organizations and are also entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B. These payments are in lieu of amounts that would otherwise be payable with respect to such individuals under sections 1814(b) and 1833(a) of the act.

Paragraph (2) of the new section 1876(a) provides that the rate of payment to such an organization is to be determined annually in accordance with regulations established by the Secretary. This rate will take into account the health maintenance organization's premiums for its other enrollees and other pertinent factors which the Secretary may prescribe. (Actuarial adjustments are to be made reflecting the difference in utilization between a health maintenance organization's members who are under age 65 and its members age 65 and over.) The rate of payment is not to exceed 95 percent of the amount the Secretary estimates would be paid if the services were furnished by sources other than a health maintenance organization.

Paragraph (3) of the new section 1876(a) provides that the payment to health maintenance organizations is to be made from the Federal hospital insurance trust fund and the Federal supplementary medical insurance trust fund. The portion of such payment to be made from the supplementary medical insurance trust fund to a health maintenance organization for a month will be equal to 200 percent of the product of (A) the number of covered enrollees in the organization in such month and (B) the monthly premium rate for supplementary medical insurance for that month. The remainder of the monthly payment will be paid from the hospital insurance trust fund.

The new section 1876(b) defines a "health maintenance organization" as a public or private organization which—

(1) provides, directly or through arrangements with others, health services to enrolled individuals on a per capita prepayment basis;

(2) provides to enrolled individuals, through qualified providers of services, all of the services and benefits covered under parts A and B of title XVIII;

(3) provides physicians' services directly through physicians who are either employees or partners of the organization or under an arrangement with an organized group (or groups) of physicians which is (or are) reimbursed for services on the basis of an aggregate fixed sum or on a per capita basis;

(4) demonstrates to the satisfaction of the Secretary proof of financial responsibility and capability to provide comprehensive

health care services (including institutional services) efficiently, effectively, and economically;

(5) has enrolled members at least half of whom are under age 65;

(6) has arrangements that assure that the health services required by its members are received promptly and appropriately and that the services received measure up to quality standards established under regulations prescribed by the Secretary; and

(7) has an open enrollment period at least once every 2 years under which it accepts eligible individuals, without underwriting restrictions, on a first-come first-accepted basis up to the limit of its capacity.

The new section 1876(c) provides that the benefits provided to an individual through a health maintenance organization will consist of—

(1) services described in sections 1812 and 1832 which are furnished by such organization in accordance with the new section 1876(e);

(2) emergency services (as defined in regulations) furnished to him by a physician, supplier, or provider of services other than the health maintenance organization, with payment being made by the organization on the individual's behalf.

The new section 1876(d) provides that (subject to the provisions of section 1876(e)) every individual who is entitled to hospital insurance benefits under part A and who is enrolled for medical insurance benefits under part B will be eligible to enroll with a health maintenance organization which serves the geographic area in which he resides.

The new section 1876(e) provides that regulations are to be prescribed to govern enrollment and termination of enrollment with a health maintenance organization.

The new section 1876(f) provides that an individual enrolled with a health maintenance organization is entitled to a hearing before the Secretary (to the same extent as is provided in section 205(b) of the act) if the amount in controversy is \$100 or more and the individual is dissatisfied because of his failure to receive without additional cost any health service to which he believes he is entitled. In any such hearing the Secretary will make the health maintenance organization a party thereto. If the amount in controversy is \$1,000 or more, the individual or the health maintenance organization will be entitled to judicial review of the Secretary's final decision.

Paragraph (1) of the new section 1876(g) provides that if the health maintenance organization provides only the services described in section 1876(c), its premium rate may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

Paragraph (2) of the new section 1876(g) provides that if the health maintenance organization provides additional services it will furnish its enrollees with information as to the division of its premium rate between the portion for the additional services and the portion for the services described in section 1876(c); the latter portion may not exceed the actuarial value of the cost-sharing provisions applicable under part A and part B.

Section 239(b) of the bill amends section 1866 of the act by adding at the end a new subsection (f) which provides that the term "provider of services" is to include a health maintenance organization if it meets the requirements of the new section 1876.

Section 239(c) of the bill provides that any health maintenance organization which has entered into an agreement with the Secretary pursuant to section 1866 of the act will be entitled to payment only as provided in the new section 1876; the provisions of section 1833 of the act do not apply.

Section 239(d) of the bill provides that the effective date of any agreement with a health maintenance organization will be specified in the agreement pursuant to regulations.

Section 239(e) of the bill amends sections 1814(a), 1833(a), and 1866(b)(2) of the act to make conforming changes.

Section 239(f) of the bill provides that these amendments will be effective with respect to services provided on or after January 1, 1971.

PART C—MISCELLANEOUS AND TECHNICAL PROVISIONS

SECTION 251. COVERAGE PRIOR TO APPLICATION FOR MEDICAL ASSISTANCE

Section 251(a) of the bill amends section 1902(a) of the Social Security Act by adding (in a new paragraph (33)) a new requirement under which State medicaid plans must provide for payments of medical assistance where care or services included under the plan were furnished in or after the third month prior to the month of application for individuals who were otherwise eligible when the care or services were received.

Section 251(b) of the bill provides that this amendment will be effective July 1, 1971.

SECTION 252. HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER THE MEDICARE PROGRAM

Section 252(a) of the bill amends section 1814(a)(2) of the Social Security Act by adding a new subparagraph (E) which provides that, in order to receive payment for inpatient hospital services in connection with a dental procedure, a physician must certify that the patient suffers from impairments which are of such severity that he requires hospitalization.

Section 252(b) of the bill amends section 1861(r) of the act to provide that a doctor of dentistry or of dental or oral surgery may make the certification described in the new subparagraph (E) of section 1814(a)(2).

Section 252(c) of the bill amends section 1862(a)(12) of the act to make it clear that payment under part A for inpatient hospital services in connection with dental procedures will not be excluded from coverage when the patient suffers from severe impairments which require that he be hospitalized.

Section 252(d) of the bill provides that these amendments will be effective with respect to admissions occurring after the second month following the month of enactment.

SECTION 253. EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID PROGRAMS

Section 253(a) of the bill amends section 1902(a) of the Social Security Act to exclude Christian Science sanatoriums from the terms "skilled nursing home" and "nursing home" for specified medicaid

purposes and thereby to exempt them from the requirements established for skilled nursing homes which relate to medical practices and activities such as maintaining an organized nursing service under the direction of a registered nurse, maintaining detailed medical records, having diagnostic and other service arrangements with general hospitals, and having a skilled nursing home administrator licensed by the State. States are relieved of the requirement that they provide regular medical review and periodic inspections of the care provided in Christian Science sanatoriums.

Section 253(b) of the bill amends section 1908(g)(1) of the act (relating to State programs for licensing nursing home administrators) to provide that the term "nursing home" contained therein does not include Christian Science sanatoriums.

Section 253(c) of the bill provides that these amendments will be effective upon the enactment of the bill.

SECTION 254. PHYSICAL THERAPY SERVICES UNDER MEDICARE PROGRAM

Section 254(a)(1) of the bill amends section 1861(p) of the Social Security Act to include, as part of "outpatient physical therapy services," physical therapy services furnished by a licensed physical therapist in his office or in the patient's home if such services are furnished in accordance with regulations including such conditions relating to health and safety as the Secretary finds necessary.

Section 254(a) (2) and (3) amend section 1833 of the act (as otherwise amended by the bill) to provide that no more than \$100 in any calendar year may be considered as incurred expenses for purposes of payments for the physical therapy services described in the amendment made by section 254(a)(1), and that reimbursement will be on the basis of the reasonable charges for such services.

Section 254(a)(4) amends section 1832(a)(2)(C) of the act to provide that the services described in the amendment made by section 254(a)(1) will not be considered as outpatient physical therapy services benefit for which reimbursement may only be made on behalf of the entitled beneficiary; thus reimbursement may either be made directly to the beneficiary for the incurred expenses or on his behalf (upon assignment by him) to the physical therapist who furnished the services.

Section 254(b) of the bill amends section 1861(p) of the act (as otherwise amended by the bill) to provide that "outpatient physical therapy services" include physical therapy services furnished by a hospital or extended care facility to an inpatient of such institution.

Section 254(c) of the bill amends section 1861(v) of the act by adding a new paragraph providing that the payment for physical therapy services furnished by a provider of services, or by a clinic, rehabilitation agency, or public health agency, or by others under arrangements with such a provider, agency, or organization, may not exceed the amount that would reasonably have been paid as salary if the services had been performed by an employee.

Section 254(d) of the bill provides that the amendments made by sections 254(a) and 254(b) will apply with respect to services furnished after December 31, 1970, and that the amendments made by section 254(c) will apply with respect to provider accounting periods beginning after the enactment of the bill.

SECTION 255. EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

Section 255(a) of the bill amends section 1838(b) of the Social Security Act (which presently provides that termination of coverage under the supplementary medical insurance program for nonpayment of premiums shall be deferred for a grace period not in excess of 90 days during which overdue premiums may be paid and coverage continued) to authorize the extension of the grace period for an additional 90 days where the Secretary determines that there was good cause for failure to pay the overdue premiums within the initial 90-day period.

Section 255(b) provides that this amendment will apply with respect to nonpayment of premiums becoming due and payable on or after the date of enactment of the bill. For purposes of the amendment any premium which became due and payable within the 90-day period immediately preceding the date of enactment is considered as becoming due and payable as of such date.

SECTION 256. EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

Section 256(a) of the bill amends section 1842(b)(3) of the Social Security Act to provide that a bill submitted or a request for payment made after the close of the calendar year following the year in which the related service was furnished may be honored notwithstanding the lapse of time if the delay in submitting the bill or in requesting the payment is due to error or misrepresentation of the Government or one of its agents and if the bill is submitted or the request for payment is made as soon as possible after the fact of such error or misrepresentation is established.

Section 256(b) of the bill provides that this amendment will apply with respect to bills submitted and requests for payment made after March 1968.

SECTION 257. WAIVER OF ENROLLMENT PERIOD REQUIREMENTS WHERE INDIVIDUAL'S RIGHTS WERE PREJUDICED BY ADMINISTRATIVE ERROR OR INACTION

Section 257(a) of the bill amends section 1837 of the Social Security Act by adding a new subsection (f), providing that where the Secretary finds that an individual's enrollment or nonenrollment in the supplementary medical insurance program is unintentional, inadvertent, or erroneous because of the error, misrepresentation, or inaction of a departmental officer, employee, or agent, the Secretary may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums).

Section 257(b) of the bill provides that this amendment will be effective as of July 1, 1966.

**SECTION 258. ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT
IN SUPPLEMENTAL MEDICAL INSURANCE PROGRAM MORE THAN THREE
YEARS AFTER FIRST OPPORTUNITY**

Section 258 of the bill amends section 1837(b) of the Social Security Act to permit eligible individuals to enroll or reenroll in the supplementary medical insurance program during any prescribed general enrollment period by eliminating the requirement that an individual must enroll (or reenroll after termination of a previous enrollment) within 3 years following the close of his initial enrollment period (or following the effective date of such termination). The restriction that no individual may enroll in the supplementary medical insurance program more than twice is retained.

**SECTION 259. WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM
SURVIVOR WHO IS WITHOUT FAULT UNDER MEDICARE PROGRAM**

Section 259(a) of the bill amends section 1870(c) of the Social Security Act (which presently provides that with respect to an overpayment there will be no adjustment as required under section 1870(b) of the act (or recovery) in any case in which the individual to whom the incorrect payment was made is without fault and where such adjustment (or recovery) would defeat the purpose of title II of the act or would be against equity and good conscience) to make its provisions applicable to any person who is without fault and subject to adjustment as provided for in section 1870(b)(4) of the act.

Section 259(b) of the bill provides that this amendment will apply with respect to waiver actions considered after the date of enactment of the bill.

**SECTION 260. REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO
ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY
MEDICAL INSURANCE PROGRAM**

Section 260(a) of the bill amends section 1842(b)(3)(C) of the Social Security Act (which presently provides that enrollees in the supplementary medical insurance program will be granted fair hearings by the carrier in cases where requests for payment are denied or are not acted upon with reasonable promptness or when the amount of payment is in controversy) to provide that a minimum amount of \$100 must be at issue before such a hearing will be granted.

Section 260(b) of the bill provides that this amendment will apply with respect to hearings requested after the date of enactment of the bill.

**SECTION 261. COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE
PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY
AND RAILROAD RETIREMENT BENEFITS**

Sections 261 (a), (b), (c), and (d) of the bill amend sections 1840 and 1841 of the Social Security Act to provide that a railroad retirement beneficiary's monthly supplementary medical insurance premiums will be deducted from his railroad retirement pension regardless

of any entitlement he may have to monthly benefits under title II of the act.

Section 261(e) of the bill amends section 1841 of the act by adding a new subsection (i) providing that the Managing Trustee of the Supplementary Medical Insurance Trust Fund is to reimburse the Railroad Retirement Board from the trust fund in such amounts as the Secretary of Health, Education, and Welfare determines to be equal to the costs incurred by the Board in making the premium deductions.

Section 261(f) of the bill provides that these amendments will apply with respect to premiums becoming due and payable after the fourth month following the month of enactment of the bill.

SECTION 262. PAYMENT FOR CERTAIN INPATIENT HOSPITAL SERVICES FURNISHED OUTSIDE THE UNITED STATES

Section 262(a) of the bill amends section 1814(f) of the Social Security Act to make medicare benefits payable for inpatient hospital services furnished outside the United States in cases where the beneficiary is a resident of the United States and the foreign hospital is closer to, or substantially more accessible from, his residence than the nearest hospital in the United States which was suitable and available for his treatment. Such benefits are to be payable without regard to whether an emergency existed or where the illness or accident occurred. (In present law section 1814(f) limits payment to emergencies occurring within the United States.) Payment for covered hospital services furnished outside the United States would be made essentially on the same basis as payment for emergency services furnished by a non-participating hospital within the United States.

Section 262(b) of the bill amends section 1861(e) of the act to provide that medicare benefits payable under the amended section 1814(f) will be payable only with respect to inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital-approval program having essentially comparable standards.

Section 262(c) of the bill makes a conforming change in section 1862(a)(4) of the act.

Section 262(d) of the bill provides that these amendments will be applicable to services furnished with respect to admissions occurring after December 31, 1970.

SECTION 263. STUDY OF CHIROPRACTIC COVERAGE

Section 263 of the bill directs the Secretary of Health, Education, and Welfare (utilizing his authority under section 1110 of the Social Security Act) to conduct a study of the coverage of services performed by chiropractors under State medicaid plans approved under title XIX of the Social Security Act to determine whether, and to what extent, chiropractic services should be covered under part B of title XVIII. The study is to focus on the limitations which should be placed upon such coverage (including payment limitations) and is to include one or more experimental, pilot, or demonstration projects designed to assist in providing under controlled conditions the information necessary to achieve the objectives of the study. The Secretary

is to report the results of the study to the Congress within 2 years after the date of enactment of the bill, together with his findings and recommendations based on the study, and on other relevant informations.

TITLE III—MISCELLANEOUS

SECTION 301. MEANING OF TERM "SECRETARY"

Section 301 of the bill makes it clear that the term "Secretary" (unless the context otherwise requires) means the Secretary of Health, Education, and Welfare when it is used in the bill and in the amendments made by the bill.

VI. SEPARATE VIEWS OF HON. CHARLES A. VANIK, OF OHIO

Although this bill provides some long-needed improvements in the social security system, I am distressed with the decision to reduce the old-age and disability insurance fund by \$30.2 billion in the next 4 years with a compounded loss including interest totaling \$54.9 billion by January 1, 1980.

The reduction of the old-age and disability tax rate was achieved by deferring the scheduled increase in the employer-employee combined contribution rate to 10 percent until January 1, 1975. Present law would have increased the combined 8.4-percent rate to 9.2 percent on January 1, 1971, and to 10 percent on January 1, 1973.

I cannot agree with the Social Security authorities who deplore the healthy growth of the social security fund. Those who criticize and question the soundness of this program are given comfort by our legislative action which diverts almost \$62.6 billion from the fund over the next 40 years.

Under regular insurance actuarial standards, the social security trust fund is far below accepted reserve requirements. The tax stretch-out further reduces the strength of the trust fund at a time of uncertainties beyond projection or prophecy.

Our action in reducing the tax rate on the old age, survivors', and disability insurance fund is an inflationary action which comes simultaneously with income tax reductions. It would seem provident to place some of the tax reduction into the retirement reserve.

Furthermore, the trust funds are becoming more substantial investors in the Federal debt. The time is not far distant when 40 percent of the Federal debt will be held by trust fund accounts. The trust fund contributions constitute the only investment in the Federal debt of millions of American taxpayers. Incredible as it may seem, the substantial investment of the trust funds in the Federal debt have served to keep the Federal interest rate and the public interest rate from reaching even greater heights.

Those who oppose the increased reserves in the social security trust fund are also those who oppose increased benefits. They are willing to shortchange the trust funds in order to reduce pressures for increased benefits and services needed by retired Americans. The worker-contributor will save a few pennies but the corporations of America will have a windfall of \$15 billion in 4 years at the expense of a stronger social security fund and a better program. This proposal is penny wise but pound foolish.

CHARLES A. VANIK.

VII. SUPPLEMENTAL REPUBLICAN VIEWS

We believe the committee did a commendable job in adopting a series of structural changes that will produce greater equity in our social security program. We are particularly pleased that the committee has acted favorably on the administration's proposals to improve benefits for widows and increase the amount that an individual may earn without losing benefits. We also support the provisions of the bill designed to improve the effectiveness and hold down the costs of the medicare, medicaid, and maternal and child health programs.

However, we must express concern about several of the actions taken by the committee. First, we are concerned about the manner and timing of the 5-percent benefit increase provided in the committee bill. Second, we are concerned about the implications of the actuarial imbalance that will exist in the fund for the immediate future, even though this imbalance is admittedly small. Finally, we deeply regret the partisan rejection of the administration's recommendation for automatically adjusting benefits in the future as the cost of living increases.

I. POOR TIMING OF THE BENEFIT INCREASE

At the outset, we want to firmly state our belief that social security beneficiaries are entitled to benefit increases to replace purchasing power lost to inflation. Additionally, we feel that Congress should periodically review the benefit schedule in the light of overall advances in economic activity. Congress has enacted benefit increases in the past in accordance with these essential principles and will continue to do so in the future.

Since 1965, Congress has increased cash benefits by 39 percent, and has also enacted the medicare program which for the aged is today equivalent to about a 30-percent increase in benefits. This record certainly reflects our sincere desire to be fair toward those relying on social security benefits.

We believe it is equally important to be fair to those who are bearing the tax burden necessary to provide these benefits. When the tax increases provided by this bill are fully effective, social security employee taxes will exceed the income taxes payable by a working man with a wife and two children (taking the higher of the standard deduction or low-income allowance) at all wage levels below \$7,170. This does not include the employer's share of the tax, although most economists agree that the economic incidence of the employer's share of the tax falls on the employee. It is also important to note that social security taxes are applied to the worker's wages without allowing any deductions or exemptions.

We simply must remember that the income that a worker can currently devote to future contingencies is limited by his ability to meet the immediate needs of his family. If the cost of social security

cuts too deeply into daily living requirements, people will begin to make unfavorable comparisons between current costs and distant benefits. If the time ever comes that current workers are unwilling to bear the cost of providing benefits to current retirees, the social security system will be in real danger and those who will stand to lose most will be the current beneficiaries.

We are concerned that the timing of the 5-percent benefit increase included in this bill, coming on top of a 15-percent increase that social security beneficiaries began receiving only last month, fails to give sufficient weight to both the benefits that should be payable and the burdens that may be reasonably imposed on today's workers.

We wholeheartedly supported the 15-percent increase enacted into law on December 30 of last year. It must be recognized, however, that in doing so Congress provided benefits nearly half again as large as was necessary to make up for increases in the cost of living. Realizing that the war against a deeply entrenched inflation resulting from years of fiscal irresponsibility could not be won overnight, we provided a cushion against further increases in the cost of living on a prospective basis. Despite this, the committee has, only 4 months after we provided a 15-percent increase, voted an additional 5-percent benefit increase payable next January 1. This results in combined increases of nearly 21 percent within a 1-year period, which is substantially above the erosion in benefits that has resulted from inflation since the last increase in 1968.

Under the proposal for automatically adjusting benefits to increases in the cost of living, which we support, it is estimated that an increase in benefits of around 5 percent would be payable at the end of 1971. It is therefore not the benefit increase that concerns us, but its timing. The practice of bunching increases of this magnitude back to back will in the long run lead to further substantial increases in the tax burdens that must be imposed.

Additionally, the timing of this increase will result in an increase in spending in the unified budget of around \$700 million in fiscal 1971. Coming on top of other increases in Federal spending and possible shortfalls in Federal revenue, the timing of this increase may seriously impair public confidence in our Government's determination to win the battle against inflation. Social security beneficiaries living on fixed incomes suffer the most from inflation. They should not be made the scapegoat for governmental programs to deal with inflation, as we recognized in supporting the recent 15 percent benefit increase. But by the same token, they will suffer the most if our determination to control inflation is seriously impaired.

II. ACTUARIAL IMBALANCE IN THE OASDI FUND DURING THE IMMEDIATE FUTURE

During the history of the social security program, tolerances have been established to determine when the social security funds are actuarially in balance. Since 1965, when estimates were placed on a 75-year basis, the fund has been considered to be actuarially in balance only when long-term level costs are financed within one-tenth of 1 percent of covered payroll. We must express our concern about action taken by the committee which provides long-term level costs that exceed income over the estimating period by 0.12 percent of covered payroll.

While the OASDI trust funds are only out of balance by 0.02 percent of payroll and should be in balance again sometime in 1971, we must express a strong word of caution. In the past, the committee has insisted that the criteria for determining actuarial soundness be strictly adhered to. We trust that the action taken by the committee in this bill does not reflect a disregard for the practice of insisting on the soundest financing, and will not provide a precedent for any changes in this policy in the future.

III. PARTISAN REJECTION OF ADMINISTRATION'S RECOMMENDATION FOR AUTOMATICALLY ADJUSTING BENEFITS

In his message to the Congress on social security, President Nixon recommended that benefits "be adjusted automatically to reflect increases in the cost of living. The uncertainty of adjustment under present laws and the delay often encountered when the needs are already apparent is unnecessarily harsh to those who must depend on social security benefits to live."

Recommendations for automatic benefit adjustments were included in both major party platforms in the last election, advocated by both presidential candidates, and have been included in legislation introduced by four Democrat members on the Ways and Means Committee.

The rejection of President Nixon's proposal on a completely partisan basis is therefore surprising and disappointing. It is a complete departure from the policies the Democratic Party pledged the American people they would work for. It was certainly anomalous for four Democrat members of the committee to vote against an escalator clause when they have introduced legislation to enact such a provision.

More than this, the partisan rejection of this constructive proposal is a disservice to all current and future beneficiaries of our social security program. The proposal would extend to social security beneficiaries for the first time the same protection against inflation that our civil service retirees have enjoyed since 1962, and that our military retirees have enjoyed since 1958.

Prompt adjustment of benefits would enable our citizens to plan their retirement with the assurance that a specified amount of real income would be consistently provided. Studies indicate that the total amount of benefit increases provided between 1954 and the end of last year was nearly identical with increases that would have been provided under a provision automatically increasing benefits. However, since Congress enacted increases on only three different occasions during this period, long delays were experienced by beneficiaries, with no increase at all being provided during the 6-year period between 1959 and 1965. Under the President's proposal for automatic benefit adjustments, benefits would have been increased six times during this period, avoiding unnecessary delay and hardship. Justice to our senior citizens requires that benefits be promptly updated.

Additionally, a provision automatically adjusting benefits would enable a busy Congress to devote time to considering solely on their merits structural improvements in the program to improve equity, facilitate administration, and increase the basic efficiency of the

program. Proposals of dubious merit having little support in the Congress have too often in the past been enacted because they were attached to legislation providing benefit adjustments that were vitally needed by social security beneficiaries. In considering structural improvements in the program, Congress would, of course, periodically review the entire benefit structure to provide adjustments over and above the automatic increases when increases in general economic productivity make such adjustments desirable.

We want to make it clear that the provision for automatic benefit adjustments does not in any way delegate to the executive branch discretion to increase taxes. In order to finance the automatic benefit increases tied to increases in the cost of living, provisions are included in the bill for periodic adjustments in the wage base to reflect increases in earnings. However, the increase in the wage base is not left to the discretion of any executive official, but is specifically tied to actual increases in the earnings of workers in covered employment.

Under the provisions for automatic benefit adjustments recommended by the administration, which the Democrat members of the committee rejected, the average wages actually paid to workers in covered employment during the first quarter of each even-numbered year would be compared with the average wages actually paid to covered workers in the first quarter of 1971. The wage base would be automatically increased by an amount equal to the increase in the earnings of covered workers that has occurred, rounded to the nearest multiple of \$600. It cannot be alleged that this leaves to anyone's discretion the right to raise or lower taxes. Changes in tax rates would continue to require specific legislation. Changes in the wage base could only result when wages increase in accordance with a very specific formula spelled out in the legislation or as a result of specific legislation. The circumstances under which taxes are payable would continue to remain where they belong, under the complete control of the Congress.

CONCLUSION

We strongly support the constructive amendments included in this bill providing structural improvements to the OASDI program, the medicare program, and the child and maternal health program. We commend the administration for making sound recommendations and working with the committee in developing needed improvements in these areas.

We have reservations concerning the timing of the 5-percent increase, the growing burden of payroll taxes on our working population, and the actuarial imbalance, though small, that will exist in the fund during the immediate future. We strongly object to the partisan rejection of the administration's constructive recommendation to provide for automatic increases in benefits commensurate with increases in the cost of living.

John W. Byrnes, Jackson E. Betts, Herman T. Schneebeli,
Harold R. Collier, Joel T. Broyhill, Barber B. Con-
able, Jr., George Bush, Rogers C. B. Morton, Charles
E. Chamberlain, Jerry L. Pettis.

Errata Sheet

Page 121 of the Section-by-Section Analysis of the Committee Report on H.R. 17550, Section 222: Eliminate the words "at least 60 days" from lines 5 and 6 at the top of page 121, and from the second and third lines from the bottom of that page.

Report of the Committee on
Finance, U. S. Senate, to
accompany H. R. 17550, Social
Security Amendments of 1970,
Senate Report No. 91-1431

SOCIAL SECURITY AMENDMENTS
OF 1970

REPORT
OF THE
COMMITTEE ON FINANCE
U.S. SENATE

TO ACCOMPANY

H.R. 17550

AN ACT TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE INCREASES IN BENEFITS, TO IMPROVE COMPUTATION METHODS, AND TO RAISE THE EARNINGS BASE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS WITH EMPHASIS UPON IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF SUCH PROGRAMS, AND FOR OTHER PURPOSES

TOGETHER WITH
SEPARATE, ADDITIONAL VIEWS



DECEMBER 11, 1970.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

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Note

A detailed table of contents of each of the general areas described above can be found at the beginning of the various parts of this report.

SOCIAL SECURITY AMENDMENTS OF 1970

DECEMBER 11, 1970.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

together with

SEPARATE, ADDITIONAL VIEWS

[To accompany H.R. 17550]

The Committee on Finance, to which was referred the bill (H.R. 17550) to amend the Social Security Act to provide increases in benefits, to improve computation methods, and to raise the earnings base under the old-age, survivors, and disability insurance system, to make improvements in the medicare, medicaid, and maternal and child health programs with emphasis upon improvements in the operating effectiveness of such programs, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

I. GENERAL STATEMENT

The bill (H.R. 17550) as passed by the House of Representatives would increase social security benefits by 5 percent and achieve other reforms of the cash benefits program. It would also make significant changes in the medicare and medicaid programs, generally to emphasize cost consciousness in the operation of these major health programs. Finally, the House bill would restructure the financing provisions of present law to insure the continued solvency of the old-age, survivors, and disability trust fund (the cash benefit program) and to restore a balance in the hospital insurance trust fund (under the medicare program).

The committee bill provides for a 10-percent increase in social security benefits and would increase the minimum benefit to \$100 per month. Presently the minimum is \$64 per month. It also provides for a new system of peer review of services rendered under the medicare and medicaid programs and establishes a new office of Inspector

General for Health Care Administration to monitor those programs in the interest of efficiency and consistency with Congressional intent. In addition, it provides for a new program of insuring against the costs of catastrophic illness.

The committee bill also modifies various provisions of the House bill and adds several new features to the portions of the bill relating to cash benefits and medicare and medicaid.

The financing features of the House bill would be modified by the committee bill to reflect the additional funds needed to pay for the higher level of benefits recommended by the committee. The solvency of the trust funds is of great concern to the Committee on Finance, just as it was to the Committee on Ways and Means of the House.

In addition to this work, the committee bill adds significant new titles to the House bill. One of these recommends enactment of the Trade Act of 1970, which accomplishes much needed reform in our tariff and trade laws, including provisions for relief for injured industries, firms, and workers.

Another new title added to the bill by the committee authorizes important tests of various welfare and workfare plans prior to enactment by Congress of new departures in welfare reform. These tests relate to the program of Aid to Families with Dependent Children; they do not concern themselves with the programs of aid to the aged, the blind, and the disabled. With respect to these adult categories, the committee bill provides for a nationwide guaranteed minimum income of \$130 per month for a single person and \$200 per month for a married couple. Important changes are also proposed by this title in the operation of the work incentive program. These changes should help ease the trend to greater and greater dependence on welfare for sustenance by family heads who are able to work but are ill-equipped to obtain jobs today. The committee bill increases the Federal commitment for expansion of child care services, through an increase in Federal matching and the creation of a Federal Child Care Corporation designed to provide an effective delivery system for these much-needed services.

Still another title of the bill provides for substantial increases in pensions to veterans with non-service-connected disabilities. Pension benefits are related to need; as social security payments are increased, the veteran's need for a pension decreases although by a considerably smaller amount than social security goes up. The amendment in this new title would prevent decreases in pensions for virtually all veteran pensioners and widows under the current law.

Finally, the committee bill includes a new title containing tax amendments generally related to programs dealt with by the bill. One calls for reporting to the Internal Revenue Service of health care payments by insurance companies and similar payments under the medicare and medicaid and other Federal health programs. Another upgrades the retirement income credit to reduce the disparity in tax treatment between persons receiving taxable retirement incomes and those receiving tax-free social security or railroad retirement benefits.

All the committee amendments are described more fully in the following parts of this report. The total value of benefits provided by the bill approximate \$10 billion in the first full year of operation, making this the largest social insurance bill, in terms of dollars, that Congress has ever acted on.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

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II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. Social Security Cash Benefits

1. PROVISIONS OF THE HOUSE BILL CHANGED, AND NEW PROVISIONS ADDED BY THE COMMITTEE

The committee made a number of changes in the provisions of the House-passed bill affecting the social security cash benefit programs. In a number of cases, the committee bill would modify or eliminate provisions of the House bill affecting select groups of beneficiaries; these changes would help make possible a 10-percent across-the-board benefit increase compared with the 5-percent increase in the House bill. Other provisions in the committee bill include a \$100 minimum benefit, an increase in the benefits for widows and widowers, an age-62 computation point for men, liberalization of the retirement test, an increase in the maximum benefits payable to a family, a reduction in the waiting period for disability benefits, and other less far-reaching but nonetheless important changes.

INCREASE IN SOCIAL SECURITY BENEFITS

Social security payments to the nearly 26 million beneficiaries on the rolls at the end of January 1971, and to those who come on the rolls after that date, would be increased by 10 percent, with a new minimum benefit of \$100. (The House-passed bill would have increased benefits by 5 percent, with a minimum benefit of \$67.20.)

The benefit increase would be effective for the month of January 1971, but would not be paid until April, and would mean additional benefit payments of \$5.0 billion in the first full year.

INCREASED WIDOWS' AND WIDOWERS' INSURANCE BENEFITS

Under present law, when benefits begin at or after age 62 the benefit for a widow (or dependent widower) is equal to 82½ percent of the amount the deceased worker would have received if his benefit had started when he was age 65. A widow can get a benefit at age 60 reduced to take account of the additional 2 years in which she would be getting benefits.

Both the House bill and the committee bill are aimed at providing benefits to a widow equal to the benefits her husband was receiving, or would have received. It was brought to the committee's attention, however, that in some cases the widow, under the House bill, would actually receive a benefit substantially higher than her husband received before his death. Under the House bill, a widow would be entitled to 100% of the amount her deceased husband would receive if he became a beneficiary after reaching age 65. On the other hand, if he actually began receiving benefits before reaching age 65, his bene-

fits would be actuarially reduced. For example, a man eligible for \$150 monthly if he retires at age 65 will receive reduced benefits of \$135 when he retires 18 months before reaching age 65. Under the House bill, his widow age 65 or older would be eligible for monthly benefits of \$150; under the committee bill, she would receive \$135, as did her husband. Generally, under the committee bill the widow would receive either 100% of the benefit her husband was actually receiving at the time of his death or, if he was not receiving benefits, 100% of the benefit he would have been eligible for at age 65.

About 2.7 million widows and widowers on the rolls at the end of January 1971 would receive additional benefits, and \$649 million in additional benefit payments would be made in the first full year.

Effective date.—January 1, 1971.

COST-OF-LIVING INCREASES

The House-passed bill would have provided for cost-of-living increases in benefits and for related increases in the tax base and in the exempt amount under the retirement test which would have subordinated the role of Congress in determining benefit levels. The committee has revised these provisions in order to stress the role of the Congress in setting social security tax and benefit levels. Under the committee bill, social security benefits would rise automatically in the event the cost of living goes up and Congress failed to legislate on social security benefits or taxes. The social security earnings limitation would increase automatically as covered earnings increase. The full cost of these automatic increases would be met equally by increases in tax rates and in the tax base, with the function of determining the base and the rates performed by the Secretary of Health, Education, and Welfare. The committee bill would provide that the automatic benefit increases would not go into effect if in the year before the year in which the increase was to be effective Congress and the President had approved a change in social security benefit levels, or a change in the schedule of social security tax rates, or a change in the social security tax base.

AGE 62 COMPUTATION POINT FOR MEN

Under present law, the method of computing benefits for men and women differs in that years up to age 65 must be taken into account in determining average earnings for men, while for women, only years up to age 62 must be taken into account. Also, benefit eligibility is figured up to age 65 for men and up to age 62 for women. These differences which provide special advantages for women would be eliminated under the committee bill and under the House-passed bill by applying the same rules to men as now apply to women.

The House-passed change would apply immediately to those already on the rolls as well as to those coming on in the future. Under the committee's bill, there would be a gradual transition to the new procedures so that the provision would apply only to those becoming entitled to benefits in the future; the number of years used in determining insured status and in computing benefits for men would be reduced in 3 steps so that men reaching age 62 in 1973, and later, would have only years up to age 62 taken into account in determining insured status and average earnings.

In the first full year, an additional \$6 million in benefits would be paid out under this provision. Under the change in benefit eligibility requirements for men, some 2,000 people—workers, their dependents, and survivors not eligible under present law—would be added to the rolls in the first year.

Effective date.—January 1, 1971.

INCREASE IN MAXIMUM FAMILY BENEFITS

The committee bill provides that families coming on the rolls after a benefit increase is enacted, as well as families already on the rolls at the time the increase is enacted, would be guaranteed the full amount (10 percent under the committee bill) of the current and future general benefit increases. Under the committee bill, maximum family benefits would range from 1.5 to 1.88 times the worker's benefit amount payable at age 65.

Effective date.—January 1, 1971.

ACTUARIAL REDUCTION FOR WOMEN

Under present law when a woman applies before age 65 for a retirement benefit based on her own earnings, her benefits are actuarially reduced to take account of the longer period over which benefits will be paid. If she subsequently applies for a wife's benefit after reaching age 65, her wife's benefit is also reduced to reflect the fact that she began to receive benefits before age 65. The House-passed bill would eliminate actuarial reduction in such cases; the committee bill would retain the provisions of present law.

BENEFITS FOR DIVORCED WOMEN

The committee bill retains the provisions of present law which require that in order to qualify for benefits as a divorced wife, divorced widow or a surviving divorced mother a woman must show that: (1) she was receiving at least one-half of her support from her former husband, or (2) she was receiving substantial contributions from her former husband, or (3) there was a court order in effect providing for substantial contributions to her support by her former husband.

The House-passed bill would delete these requirements.

WAITING PERIOD FOR DISABILITY BENEFITS

Under present law there is a six-month waiting period before a disabled person is eligible for social security disability insurance benefits. The committee added to the House bill a provision to reduce the waiting period for disability benefits by two months, so that benefits would be payable on the basis of a four-month waiting period, rather than a six-month period.

About 140,000 people—disabled workers and their dependents and disabled widows and widowers—would be able to receive a benefit for January 1971 as a result of this provision. About \$185 million in additional benefits would be paid out during the first full year.

Effective date.—January 1, 1971.

CHILDHOOD DISABILITY BENEFITS

The committee bill, like the House bill, would provide childhood disability benefits for the disabled child of an insured retired, deceased, or disabled worker, if his disability began before age 22, rather than before 18 as under present law. The committee added a new provision to permit a person who was entitled to childhood disability benefits to become re-entitled if he again becomes disabled within 7 years after his prior entitlement to such benefits was terminated.

About 13,000 people—disabled children and their mothers—would immediately become eligible for benefits, primarily as a result of extending the age limit to 22. About \$13 million in additional benefits would be paid out during the first full year.

Effective date.—January 1, 1971.

DISABILITY BENEFITS AFFECTED BY THE RECEIPT OF WORKMEN'S COMPENSATION

The committee deleted the provision in the House bill modifying the workmen's compensation offset provisions to raise the ceiling on income from combined workmen's compensation and disability insurance benefits from 80 percent to 100 percent of the disabled worker's average current earnings before the onset of his disability.

DISABILITY INSURANCE BENEFITS FOR THE BLIND

The House-passed bill contained a provision which would eliminate the general recency-of-work requirement for people who meet the definition of blindness in the Social Security Act. The committee bill revises the requirements for paying disability insurance benefits to blind people. Under the committee revision, disability insurance benefits would be payable to any blind person (as defined in the law) who has credit for 6 quarters of social security coverage, without regard to his ability to work.

About 225,000 people, blind workers and their dependents, would become immediately eligible for monthly benefits. About \$225 million in additional benefits would be paid out during the first full year.

Effective date.—January 1, 1971.

ADOPTION OF CHILD BY RETIRED OR DISABLED WORKER

The committee broadened the provision of the House-passed bill which would change the provisions of present law relating to the payment of benefits to a child (other than a natural child or a stepchild) who is adopted by a disability insurance beneficiary after the latter becomes entitled to benefits. Under the committee bill, the child, adopted when a disabled or retired worker is entitled to benefits, would be able to get child's benefits based on the worker's earnings if: (1) the adoption was decreed by a court of competent jurisdiction within the United States, (2) the child lived with the worker in the United States for the year before the worker became disabled or entitled to an old-age or disability insurance benefit, (3) the child received at least one-half of his support from the worker for that year, and (4) the child was under age 18 at the time he began living with the worker.

Effective date.—January 1, 1971.

REFUND OF SOCIAL SECURITY TAX TO MEMBERS OF CERTAIN RELIGIOUS FAITHS OPPOSED TO INSURANCE

Under present law, members of certain religious sects, who have conscientious objections to social security by reason of their adherence to the established teachings of the sect, may be exempt from the social security self-employment tax provided they also waive their eligibility for social security benefits. This exemption was written largely to relieve the Old Order Amish from having to pay the social security tax when, because of their religious beliefs, they would never draw social security benefits.

The committee bill would extend the exemption (by a refund or credit against income taxes at year end) from social security taxes to members of the sect who are "employees" covered by the Social Security Act as well as the "self-employed" members of the sect. The employee would have to file an application for exemption from the tax and waive his eligibility for social security and medicare benefits as the self-employed members must presently do. The provision specifically provides that there would be no forgiveness of the employer portion of the social security tax as the committee believes this would create an undesirable preference in the statute.

TRUST FUND EXPENDITURES FOR REHABILITATION SERVICES

The committee added to the House bill a provision to authorize an increase in the amount of social security trust fund monies that may be used to pay for the costs of rehabilitating social security disability beneficiaries. The amount would be increased from 1 percent of the previous year's disability benefits to $1\frac{1}{4}$ percent for fiscal year 1972 and to $1\frac{1}{2}$ percent for fiscal year 1973 and subsequent years.

UNDERPAYMENTS

The committee added a provision to the House bill under which additional relatives (by blood, marriage, or adoption) would be added to the present categories of persons listed in the law who may receive social security cash payments due a deceased beneficiary under title II of the Social Security Act.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

Present law provides for noncontributory social security wage credits of up to \$100 a month, in addition to credit for basic pay, for military service performed after 1967. The committee bill, like the House bill, would provide that the additional wage credits would be extended to service in the period from 1957 (when military service was first covered under social security) through 1967. In addition, the committee bill would make a change in the way the additional credit is computed from \$100 for each month of service to \$300 for each quarter of service. The additional wage credits would affect approximately 130,000 beneficiaries immediately; about \$35 million in additional benefits would be paid out in the first full year.

Effective date.—January 1, 1971.

2. PROVISIONS OF THE HOUSE BILL THAT WERE NOT CHANGED BY THE COMMITTEE

SPECIAL PAYMENTS TO PEOPLE AGE 72 AND OLDER

Under present law the special payments of \$46 a month for an individual and \$69 for a couple made to people age 72 and over who have not worked under the program long enough to qualify for regular cash benefits. Under the bill, the payments would be increased by 5 percent to \$48.30 a month for an individual and \$72.50 for a couple.

The benefit increase would be effective for the month of January 1971 but would not be paid until April.

REDUCED BENEFITS FOR WIDOWERS AT AGE 60

The 1965 amendments lowered from 62 to 60 the age of eligibility for widows but left the age of eligibility for dependent widowers at age 62. The bill provides that widowers who have attained age 60 would be eligible for reduced benefits, as widows are under present law.

Effective date.—January 1, 1971.

LIBERALIZATION OF THE RETIREMENT TEST

The committee bill, like the House bill, provides an increase from \$1,680 to \$2,000 in the amount a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year.

Under present law, each \$2 earned between \$1,680 and \$2,880 results in a \$1 reduction in benefits; each dollar earned above \$2,880 reduces benefits by \$1. The bill would provide for a \$1 reduction for each \$2 earned with respect to all earnings above \$2,000, not just those between \$2,000 and \$3,200.

For 1971 about 650,000 beneficiaries would receive additional benefits, and about 380,000 persons who would receive no benefits under present law would receive some benefits. Additional benefit payments for the first full year would be about \$404 million.

Effective date.—Taxable years ending after 1970.

DISABILITY INSURANCE BENEFITS APPLICATIONS FILED AFTER DEATH

The committee bill would permit disability insurance benefits (and dependents' benefits based on the worker's entitlement to disability benefits) to be paid to the disabled worker's survivors if an application for benefits is filed within 3 months after the disabled worker's death.

Effective date.—Deaths in and after year of enactment.

PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN A SOCIAL SECURITY NUMBER

Under present law, penalties are not provided for individuals who give false information in order to secure multiple social security

numbers with an intent to conceal their true identities. This has led to a number of problems in private industry and in the administration of Government programs. Therefore, the committee bill, like the House bill, would provide criminal penalties if an individual willfully furnishes false information with the intent to deceive the Secretary of Health, Education, and Welfare for the purpose of obtaining more than one social security number or of establishing a social security record under a different name. Upon conviction, an individual shall be fined not more than \$1,000, or imprisoned for not more than one year, or both.

OTHER CASH BENEFIT AMENDMENTS

The committee also deleted the House-passed amendment providing social security coverage for Federal Home Loan Bank employees and adopted amendments relating to widows who remarry, retroactive payments for certain disabled people, temporary employees of the Government of Guam, policemen and firemen in Idaho and policemen in Missouri, certain public hospital employees in New Mexico, registrars of voters in Louisiana, certain U.S. citizens who are self-employed outside the United States and certain part-time and student employees of State and local governments in Nebraska. Other amendments included in the committee's bill relate to the treatment of earnings of self-employed people paying taxes on a fiscal year basis, recomputation of benefits based on combined railroad and social security earnings and payment to a child entitled on the record of more than one worker.

B. Medicare and Medicaid

1. PROVISIONS OF THE HOUSE BILL THAT WERE NOT SUBSTANTIALLY CHANGED BY THE COMMITTEE

RELATIONSHIP BETWEEN MEDICARE AND FEDERAL EMPLOYEES BENEFITS

The committee bill would require that effective January 1, 1972, no payment would be made under medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime, the Secretary of Health, Education, and Welfare certifies that the Federal employees health benefits program has been modified to make available coverage supplementary to medicare benefits and that Federal employees and retirees age 65 and over will continue to have the benefit of a Government contribution toward their health insurance premiums.

HOSPITAL INSURANCE FOR THE UNINSURED

People reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare. Enrollment for supplementary medical insurance is also required. Those who enroll would pay the full cost of the protection—estimated at \$27 a month at the beginning of the program, and rising as hospital costs rise. States and public organizations, through agreements with the Secretary, would be permitted to purchase such protection on a group basis for their retired (or active) employees age 65 or over.

LIMITATION ON RECOGNITION OF PHYSICIANS' FEE INCREASES

Charges determined to be reasonable under the present criteria in the medicare, medicaid, and maternal and child health law would be limited by providing: (a) that after enactment of the bill medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the previous elapsed calendar year; (b) that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lower levels at which such supplies, equipment and services are widely available in a locality.

TERMINATION OF PAYMENTS TO SUPPLIERS OF SERVICES WHO ABUSE THE MEDICARE PROGRAM

The Secretary of Health, Education, and Welfare would be given authority to terminate payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. Program review teams would be established to furnish the Secretary professional advice in carrying out this authority.

REPEAL OF MEDICAID PROVISION REQUIRING EXPANDED PROGRAMS

The requirement in present law that States have comprehensive medicaid programs by 1977 would be repealed.

STATE DETERMINATION OF REASONABLE HOSPITAL COSTS

States would be permitted to pay hospitals on the basis of their own determination of reasonable cost, provided there is assurance that the medicaid program would pay the actual cost of hospitalization of medicaid recipients.

GOVERNMENT PAYMENT NO HIGHER THAN CHARGES

Payments for institutional services under the medicare, medicaid, and maternal and child health programs could not be higher than the charges regularly made for those services.

FEDERAL MATCHING FOR MODERN CLAIMS PROCESSING SYSTEMS

Federal matching at the 90-percent rate would be available under medicaid for the States to set up mechanized claims processing and informational retrieval systems. Federal matching for the continuing operation of such systems would be at the 75-percent rate.

PROHIBITION OF REASSIGNMENTS

Medicare (part B) and medicaid payments to anyone other than a patient, his physician, or other person providing the service, would generally be prohibited, unless the physician (or, in the case of medicaid, another type of practitioner) is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

UTILIZATION REVIEW IN MEDICAID

Hospitals and skilled nursing homes participating in the medicaid and maternal and child health programs would be required to have the same type of utilization review committee with the same functions as are required in the medicare program. (Any such committee actually performing such functions for medicare purposes would apply these to medicaid cases.)

MEDICAID DEDUCTIBLES FOR THE MEDICALLY INDIGENT

Present law requires medicaid cost sharing provisions for the medically-indigent to vary directly with the amount of the recipient's income.

This has created an impossible administrative situation for States desiring to apply uniform reasonable copayment requirements (for example, 50 cents or \$1 per prescription).

The amendment would permit States to employ reasonable cost-sharing provisions with respect to health services for the medically indigent without requiring variations because of differences in income levels of different medically indigent recipients.

TERMINATING PAYMENT WHERE HOSPITAL ADMISSION NOT NECESSARY UNDER MEDICARE

If the utilization review committee of a hospital or extended care facility, in its sample review of admissions, finds a case where institutionalization is no longer necessary, payment would be cut off after 3 days. This provision parallels the provision in present law under which long-stay cases are cut off after 3 days when the utilization review committee determines that institutionalization is no longer required.

ROLE OF STATE HEALTH AGENCIES IN MEDICAID

State health or other appropriate State medicaid agencies would be required to perform certain functions under the medicaid and maternal and child health programs relating to the quality of the health care furnished to recipients.

RETROACTIVE COVERAGE UNDER MEDICAID

States would be required to cover under medicaid the cost of health care provided to an eligible individual during the 3-month period before the month in which he applied for medicaid.

CERTIFICATION OF HOSPITALIZATION FOR DENTAL CARE

A dentist would be authorized to certify to the necessity for hospitalization to protect the health of a medicare patient who is hospitalized for noncovered dental procedures.

CHRISTIAN SCIENCE SANATORIUMS UNDER MEDICAID

Christian Science sanatoriums would be exempted from the medicaid requirement that they have a licensed nursing home administrator and from other inappropriate skilled nursing home requirements.

GRACE PERIOD FOR PAYING MEDICARE PREMIUM

Where there is good cause for a medicare beneficiary's failure to pay supplementary medical insurance premiums, an extended grace period of 90 days would be provided.

EXTENSION OF TIME FOR FILING MEDICARE CLAIMS

The time limit for filing supplementary medical insurance claims would be extended where the medicare beneficiary's delay is due to administrative error.

WAIVER OF ENROLLMENT REQUIREMENTS IN CASES OF ADMINISTRATIVE ERROR

Where an individual's enrollment rights under part B of medicare have been prejudiced because of inaction or error on the part of the Government, the Secretary would be authorized to provide equitable relief to the individual.

ENROLLMENT UNDER MEDICARE

Eligible individuals would be permitted to enroll under medicare's supplementary medical insurance program during any prescribed enrollment period. Beneficiaries would no longer be required to enroll within 3 years following first eligibility or a previous withdrawal from the program. Relief would be provided where administrative error has prejudiced an individual's right to enroll in medicare's supplementary medical insurance program.

WAIVER OF MEDICARE OVERPAYMENT

Where incorrect medicare payments were made to a deceased beneficiary, the liability of survivors for repayment could be waived if the survivors were without fault in incurring the overpayment.

MEDICARE FAIR HEARINGS

Fair hearings, held by medicare carriers in response to disagreements over amounts paid under supplementary medical insurance, would be conducted only where the amount in controversy is \$100 or more.

COLLECTION OF MEDICARE PREMIUM BY RAILROAD RETIREMENT BOARD

Where a person is entitled to both railroad retirement and social security monthly benefits, his premium payment for supplementary medical insurance benefits would be deducted from his Railroad Retirement benefit in all cases.

2. PROVISIONS OF THE HOUSE BILL MODIFIED BY THE COMMITTEE

LIMITATION ON FEDERAL PAYMENT FOR DISAPPROVED EXPENDITURES

Reimbursement amounts to providers of health services under the medicaid, medicare, and maternal and child health programs for capital costs, such as depreciation and interest, would not be made with respect to large capital expenditures which are inconsistent with State or local health facility plans. The committee added a provision which would require States which apply this provision to establish an appeals mechanism at the State level for purposes of considering adverse decisions.

EXPERIMENTS AND PROJECTS IN PROSPECTIVE REIMBURSEMENT AND INCENTIVES FOR ECONOMY

The Secretary of Health, Education, and Welfare would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under the medicare, medicaid and maternal and child health programs. In addition, the Secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy. The committee added a provision which would allow the Secretary to include in such projects community mental health centers, and ambulatory care facilities.

LIMITS ON COSTS RECOGNIZED AS REASONABLE

The Secretary of Health, Education, and Welfare would be given authority to establish and promulgate limits on provider costs to be recognized as reasonable under medicare based on comparisons of the cost of covered services by various classes of providers in the same geographical area. Hospitals and extended care facilities could charge beneficiaries for the costs of services in excess of those that are necessary to the efficient delivery of needed health services (except in the case of an admission by a physician who has a financial interest in the facility). The committee added a provision which would further define unreasonable costs as including those resulting from gross inefficiency.

LIMITATION ON FEDERAL MEDICAID MATCHING

The House bill provided for a one-third cutback in Federal medicaid matching after a medicaid patient had received 90 days of care in a skilled nursing home or 90 days in a mental hospital or 60 days in a general hospital in a year. The committee substituted for the House section a provision which would authorize the Secretary of HEW to reduce the matching selectively in those States where he finds inadequate medical audit and utilization review. The cutback in matching would be related to the degree of excessive costs resulting from inadequate review and audit.

PAYMENT FOR SUPERVISORY PHYSICIANS IN TEACHING HOSPITALS

The committee modified the provision in the House bill which would provide for payment for services of certain teaching physicians on a cost basis and would make fee-for-service reimbursement contingent on general billing for such services to all patients and collection from those able to pay. Under the committee modification, reimbursement of physician time in the teaching service would be determined on a cost or cost-equivalent basis. Reimbursement for such services would be made on a reasonable-charge basis if the hospital had, in the 2-year period ending in 1967, and subsequently, customarily charged all patients and collected from a majority of patients on a fee-for-service basis, or if a bonafide private patient relationship had been established.

INSTITUTIONAL PLANNING AND BUDGETING

Health institutions under the medicare program would be required to have a written plan reflecting an operating budget and a capital expenditure budget. The committee clarified this provision to stipulate that the operating budget would not have to be a detailed item budget.

MODIFICATIONS IN EXTENDED CARE AND HOME HEALTH BENEFITS

The committee modified the provision of the House bill which would authorize the Secretary of Health, Education, and Welfare to establish presumptive periods of coverage on the basis of a physician's certification for patients admitted to an extended care facility or started on a home health plan. The committee provides that, to the extent feasible, pre-admission review of extended care admissions would be required and unless disapproved, coverage upon admission would continue for the lesser of (1) the initially certified period, (2) until notice of disapproval, or (3) 10 days. Where certifications and evidence were provided on a timely basis, any subsequent determination (for purposes of determining medicare payment liability) that the patient no longer required covered care would be effective 2 days after notification to the facility. The committee provides for a similar approach to the determination of coverage of home health services.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Medicare beneficiaries could choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). Medicare would contract with such organization, and would reimburse them on a capitation basis at a rate equivalent to 95 percent of the per capita costs of medicare beneficiaries in the area with actuarial adjustments taking into account variations in patient mix. Profits accruing to the organization, beyond their retention rate for non-medicare members would be passed to the medicare enrollees in the form of expanded benefits. The committee substantially tightened the provision so as to define more specifically the quality standards and reimbursement mechanisms which would apply to the organizations as well as including additional safeguards against potential abuse and exploitation.

PHYSICAL AND OTHER THERAPY SERVICES UNDER MEDICARE

The committee removed the provision in the House bill which would authorize reimbursement up to \$100 for physical therapy services in a therapist's office.

The committee modified the limitation on reimbursement for institutional therapy services by changing the limitation from a "salary equivalent" to a "salary related" basis, and also extended the limitation to apply to other therapists, dieticians, social workers and medical records librarians for their services provided in an institutional setting.

MEDICARE BENEFITS FOR PEOPLE LIVING NEAR U.S. BORDER

The House bill provides that medicare beneficiaries living in the border areas of the United States would be entitled to covered inpatient hospital care if the hospital they use is closer to their residence than a comparable U.S. hospital and if it has been accredited by a hospital approval program with standards comparable to medicare standards. The committee added to the House bill a provision extending coverage in these cases to physicians' and ambulance services furnished in conjunction with covered foreign hospital care.

3. NEW PROVISIONS ADDED BY THE COMMITTEE

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The committee provided for the establishment of Professional Standards Review Organizations formed by organizations representing substantial numbers of practicing physicians in local areas to assume responsibility for comprehensive and ongoing review of services provided in the medicare and medicaid programs. The purpose of the amendment is to assure proper utilization of care and services provided in medicare and medicaid through a formal professional mechanism representing the broadest possible cross-section of physicians in an area. Appropriate safeguards are included so as to adequately provide for protection of the public interest and to prevent pro forma assumption and carrying out of the vitally important review activities in the two highly-expensive programs. The amendment provides for the use by the PSRO of effective utilization review committees in hospitals and medical organizations.

CONFORM MEDICARE AND MEDICAID STANDARDS FOR NURSING FACILITIES

The committee added to the House bill a provision which would require that health, safety, environmental, and staffing standards for extended care facilities be uniform with those established for skilled nursing homes under medicaid.

INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

An Office of Inspector General for Health Administration would be established within the Department of Health, Education, and Welfare. The Inspector General would be appointed by the President, would report to the Secretary, and would be responsible for reviewing and auditing the social security health programs on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the law.

PROFICIENCY EVALUATION OF OTHERWISE DISQUALIFIED HEALTH CARE PERSONNEL

The committee bill would require the Secretary of Health, Education, and Welfare to develop and employ proficiency examinations to determine whether health care personnel, not otherwise meeting spe-

cific formal criteria now included in medicare regulations, have sufficient training, experience, and professional competence to be considered qualified personnel for purposes of the medicare program.

PENALTY FOR FRAUDULENT ACTS UNDER THE MEDICARE AND MEDICAID PROGRAMS

The committee added to the House bill a provision which would broaden the present penalty provisions relating to the making of a false statement or representation of a material fact in any application for medicare payments, to include the soliciting, offering, or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral, by providers of health care services. The penalty for such acts, as well as the acts currently subject to penalty under medicare, would be imprisonment up to one year, a fine of \$10,000, or both. In addition, the committee bill provides that similar penalty provisions apply under medicaid.

The committee also provided that anyone who knowingly and willfully makes, or induces the making of, a false statement of material fact with respect to the conditions and operation of a health care facility or home health agency in order to secure medicare or medicaid certification of the facility or agency, would be guilty of a misdemeanor punishable by up to 6 months' imprisonment, a fine of not more than \$2,000, or both.

INCLUSION OF AMERICAN SAMOA AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS UNDER TITLE V

The committee bill would include the Trust Territory of the Pacific Islands and American Samoa as eligible to receive funds under the maternal and child health and crippled children programs (title V).

PROVIDE FOR REASONABLE APPROVAL OF RURAL HOSPITALS

The committee added to the House bill a provision which would authorize the Secretary of Health, Education, and Welfare to waive, on an annual basis, the requirement that an access hospital have registered professional nurses on duty around the clock, but only if he finds that the hospital: (a) has made, and is continuing to make, a bona fide effort to comply with the nursing staff requirement but is unable to employ the qualified personnel necessary because of nursing personnel shortages in the area and has an RN on the daytime shift; (b) is located in a geographical area in which hospital facilities are in short supply; and (c) nonparticipation of the "access" hospital would seriously reduce the availability of hospital services to beneficiaries residing in the area. The waiver authority would expire December 31, 1975.

CONSULTANTS FOR EXTENDED CARE FACILITIES

The committee added to the House bill a provision to authorize State agencies to provide consultative services to those extended

care facilities which request them in such specialty areas as maintenance of medical records and the formulation of policies governing the provision of dietary and social services. Medicare payment would be made directly to the State agency for the costs incurred in rendering these consultative services. The provision of such services by the State would satisfy the medicare requirements relating to the use of consultants in the appropriate specialty areas.

PUBLIC ACCESS TO RECORDS CONCERNING INSTITUTIONS' QUALIFICATIONS

The committee added to the House bill a provision under which the Secretary of Health, Education, and Welfare would be required to make reports of an institution's significant deficiencies (such as deficiencies in the areas of staffing, fire, safety, and sanitation) a matter of public record readily and generally available at social security district offices if, after a reasonable lapse of time (not to exceed 90 days), such deficiencies were not corrected.

SIMPLIFIED REIMBURSEMENT OF EXTENDED CARE FACILITIES

The committee provision would authorize the Secretary of Health, Education, and Welfare to adopt (and adjust as specified), as reasonable-cost payments for extended care facilities in any State, the rates developed in that State under medicaid for reimbursement of skilled nursing care, if the Secretary finds that they are based upon reasonable analyses of costs of care in comparable facilities.

AUTHORITY FOR ESTABLISHING LIENS TO PERMIT RECOVERY OF OVERPAYMENTS

The committee added a provision to the House bill to facilitate the recoupment of overpayments to providers of services by authorizing the Secretary of Health, Education, and Welfare, when he determines it to be necessary for purposes of recovering an overpayment to a provider, to establish a lien in favor of the Government in the amount of the overpayment, preserving in the course of such action the right of the provider to contest the amount of the overpayment and to seek release of the lien to clear title.

DIRECT LABORATORY BILLING

The committee bill would authorize direct payment to laboratories for diagnostic tests at a negotiated rate provided that such rate does not exceed the amount which is payable under present law.

REFUNDING OF EXCESS MEDICARE PREMIUMS

The committee bill would authorize the refunding of excess medicare premiums paid prior to a beneficiary's death.

WAIVER OF RECOVERY OF ERRONEOUS PAYMENT

The committee provision would limit medicare's right of recovery of an erroneous payment to a three-year period from the date of the payment, where the institution or person involved acted in good faith. Similarly, the Secretary of H.E.W. would specify a reasonable period of time (not to exceed 3 years) after which medicare would not be required to accept claims for underpayment or nonpayment.

PROVIDER REIMBURSEMENT APPEALS BOARD

The committee amendment would establish an appeals board to hear appeals on reimbursement decisions made by intermediaries, under certain conditions, and where the amount at issue was \$10,000 or more.

PROSTHETIC LENSES FURNISHED BY OPTOMETRISTS

The committee amended the definition of physician in medicare to include a licensed doctor of optometry, but only with respect to establishing the medical necessity of prosthetic lenses.

CHIROPRACTORS

The committee amendment would delete the study of chiropractic services called for in the House bill and would substitute a provision which would provide for the coverage under medicare of services involving manipulation of the spine by licensed chiropractors, if the chiropractor meets certain minimum standards established by the Secretary of Health, Education, and Welfare. The same limitations on chiropractic services would also be applicable to States providing such care under medicaid.

COLOSTOMY SUPPLIES

The committee provided for the inclusion of materials directly related to the care of colostomies as a reimbursable expense under medicare.

SECTION 1902(d)

The committee added a provision to the House bill which would repeal section 1902(d) which requires States to maintain their level of fiscal expenditures from year-to-year in their medicaid programs.

Separately, the committee also provided that the 1902(d) maintenance of fiscal effort provision would not apply to Missouri effective for the year beginning July 1, 1970.

INCREASE IN MAXIMUM FEDERAL MEDICAID MATCHING FOR PUERTO RICO

The \$20 million ceiling on Federal medicaid matching for Puerto Rico would be raised to \$30 million under the committee provision.

HEALTH SCREENING OF CHILDREN

The committee would authorize the Secretary to establish orderly priorities in the implementation of the presently required health care screening for children programs, with initial priority being given to pre-school children.

RELATIONSHIP BETWEEN MEDICAID AND COMPREHENSIVE HEALTH PROGRAMS

The committee bill would permit a State to make arrangements with comprehensive health care programs for the delivery of services on a pre-paid basis to medicaid recipients, subject to the approval of the Secretary.

INTERMEDIATE CARE FACILITIES

Under the committee amendment, the intermediate care provision would be transferred from title XI to title XIX. An ICF would be required to have at least one full-time licensed practical nurse on its staff, and care in ICF's would be subject to professional audit and utilization review requirements. The mentally retarded receiving active treatment in public institutions meeting appropriate standards established by H.E.W. would be eligible for Federal matching funds.

TERMINATION OF NURSING HOME ADMINISTRATORS ADVISORY COUNCIL

The committee would terminate the Advisory Council on December 31, 1970. Under present law the council would be terminated December 31, 1971.

COVERAGE OF MENTALLY ILL CHILDREN UNDER MEDICAID

The committee bill would authorize coverage of inpatient care in State and local mental institutions for medicaid recipients under age 21, provided that the care consists of active treatment, that it is provided in an accredited institution, and that the State maintain its own level of fiscal expenditure for care of the mentally ill under 21.

DEFINITION OF "PHYSICIAN" IN MEDICAID

The committee bill would define "physician" in title XIX to mean a doctor of medicine or a doctor of osteopathy.

75 PERCENT MEDICAID MATCHING FUNDS FOR PROFESSIONAL MEDICAL PERSONNEL

The present 75 percent Federal medicaid matching rate for professional medical personnel in State agencies would be expanded to also include such personnel who, on a contract or similar basis, undertake independent professional and medical audits of medicaid patients.

C. Catastrophic Health Insurance Program

The committee added to the House bill an amendment which would establish a program of catastrophic health insurance under the Social Security Act for all persons under age 65 who are insured under social security, their spouses and dependent children, as well as all persons under age 65 who are entitled to retirement, survivors, or disability benefits under title II of the act. The health services to be covered, and the applicable exclusions, are the same as under the medicare program, except that there would be no upper limit on covered hospital or extended care days or home health visits. Under the catastrophic health insurance program, benefits would be payable toward the costs of inpatient hospital services and post-hospital extended care services above an annual deductible of 60 days of inpatient hospital care for each individual, subject to a daily coinsurance amount. The program would also cover 80 percent of reasonable costs incurred for home health care and hospital outpatient services, and 80 percent of reasonable charges incurred for other covered medical services above an annual deductible amount which would initially be set at \$2,000 per family and which would rise in accordance with any increases in the physicians' services component of the Consumer Price Index. The program could be administered through regular medicare administrative procedures and subject to all utilization, cost, quality and administrative controls applicable under that program. Coverage under the program would be effective beginning January 1, 1972, and the financing provisions necessary to pay for the additional benefits would become effective at the same time.

(29)

D. Financing of Social Security Trust Funds

In order to pay for the additional costs of the social security changes proposed in the committee bill, including the new catastrophic illness insurance and the existing actuarial deficit in the hospital insurance program, the social security tax base would be increased from \$7,800 a year to \$9,000 a year, starting January 1, 1971, as in the House-passed bill.

In addition, a new schedule of taxes would be provided. Like the schedule of taxes proposed in the House bill, the committee bill would decrease the taxes paid under the cash benefits program over the next few years, and increase the taxes paid under the hospital insurance program. Also, the committee bill provides an additional tax of 0.3 percent in 1972, rising to 0.4 percent in 1980 to pay for the catastrophic illness insurance provided in the bill.

The following table compares the tax rates and the maximum taxes under present law under the House-passed bill and under the committee bill:

SOCIAL SECURITY TAX RATES AND MAXIMUM ANNUAL SOCIAL SECURITY TAXES FOR EMPLOYEES, EMPLOYERS, AND SELF-EMPLOYED

Year	Employees and employers, each				Self-employed					
	OASDI (percent)	HI (percent)	CI (percent)	Total (percent)	Maximum tax	OASDI (percent)	HI (percent)	CI (percent)	Total (percent)	Maximum tax
Present law: ¹										
1970-----	4.2	0.6	-----	4.8	\$374.40	6.3	0.6	-----	6.9	\$538.20
1971-72-----	4.6	0.6	-----	5.2	405.60	6.9	0.6	-----	7.5	585.00
1973-75-----	5.0	0.65	-----	5.65	440.70	7.0	0.65	-----	7.65	596.70
1976-79-----	5.0	0.7	-----	5.7	444.60	7.0	0.7	-----	7.7	600.60
1980-86-----	5.0	0.8	-----	5.8	452.40	7.0	0.8	-----	7.8	608.40
1987 and after-----	5.0	0.9	-----	5.9	460.20	7.0	0.9	-----	7.9	616.20
House bill: ²										
1970-----	4.2	0.6	-----	4.8	374.40	6.3	0.6	-----	6.9	538.20
1971-74-----	4.2	1.0	-----	5.2	468.00	6.3	1.0	-----	7.3	657.00
1975-79-----	5.0	1.0	-----	6.0	540.00	7.0	1.0	-----	8.0	720.00
1980 and after-----	5.5	1.0	-----	6.5	585.00	7.0	1.0	-----	8.0	720.00
Senate Finance Committee bill: ²										
1971-----	4.4	0.8	-----	5.2	468.00	6.6	0.8	-----	7.4	666.00
1972-----	4.4	0.8	0.3	5.5	495.00	6.6	0.8	0.3	7.7	693.00
1973-74-----	4.4	0.9	0.3	5.6	504.00	6.6	0.9	0.3	7.8	702.00
1975-79-----	5.0	1.0	0.35	6.35	571.50	7.0	1.0	0.35	8.35	751.50
1980-85-----	5.5	1.1	0.4	7.0	630.00	7.0	1.1	0.4	8.5	765.00
1986 and after-----	6.1	1.1	0.4	7.6	684.00	7.0	1.1	0.4	8.5	765.00

¹ Tax rates apply to annual earnings up to \$7,800.² Assumes tax rates apply to annual earnings up to \$9,000 after 1970.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE—H.R. 17550 AS REPORTED BY SENATE FINANCE COMMITTEE
 1ST-YEAR BENEFIT COSTS AND NUMBER OF PERSONS AFFECTED UNDER THE BILL AS PASSED BY THE HOUSE
 OF REPRESENTATIVES AND AS REPORTED BY THE SENATE FINANCE COMMITTEE

Provision	1st-year benefit costs ¹ (millions)		Present law beneficiaries immediately affected ² (thousands)		Newly eligible persons ³ (thousands)	
	House bill	Senate Finance Committee bill	House bill	Senate Finance Committee bill	House bill	Senate Finance Committee bill
Total.....	\$3,970	\$6,535	(⁴)	(⁴)	\$504	\$624
General benefit increase.....	1,729	5,003	\$26,300	\$26,300	6	6
Modified retirement test.....	404	404	650	650	380	380
Age 62 computation point.....	1,040	6	10,200	-----	60	-----
Increased benefits for widows and widowers.....	689	649	3,300	2,700	-----	-----
Shorten disability waiting period to 4 months.....	(⁵)	185	(⁵)	140	(⁵)	-----
Noncontributory credits for military service after 1956.....	35	35	130	130	-----	-----
Children disabled at ages 18 to 21.....	11	13	-----	-----	13	13
Liberalized provisions for blind workers.....	25	240	-----	-----	30	225
Election to receive larger future benefits by certain beneficiaries eligible for more than 1 actuarially reduced benefit.....	17	(⁵)	100	(⁵)	-----	(⁵)
Liberalized workmen's compensation offset.....	7	(⁵)	55	(⁵)	5	(⁵)
Eliminate support requirement for divorced wives and surviving divorced wives.....	13	(⁵)	-----	(⁵)	10	(⁵)

¹ Represents additional benefit payments in fiscal year 1972.

² Present law beneficiaries whose benefit for the effective month would be increased under the provision.

³ Persons who cannot receive a benefit under present law for the effective month, but who would receive a benefit for such month under the provision.

⁴ Figures not additive because a beneficiary may be affected by more than 1 provision.

⁵ Provision not included.

E. Trade Act of 1970

PURPOSES

The committee's trade amendment (Title III of this bill) is derived, with changes, from H.R. 18970 which passed the House of Representatives on November 19, 1970.

In brief, the general purposes of the Committee's trade amendment are:

- (1) To provide to the President limited tariff-reducing authority for compensatory purposes until July 1, 1975;
- (2) To strengthen our unfair trade practice statutes and thus enable industry and workers who are adversely affected by unfair foreign trade practices to receive a fair opportunity for relief;
- (3) To revise the adjustment assistance and tariff adjustment procedures and criteria in the Trade Expansion Act of 1962, and provide a fair opportunity for injured industries, firms, and workers to receive adequate and prompt relief;
- (4) To establish import quotas on textiles and footwear, unless:
(a) the President finds them not to be in the national interest or (b) voluntary agreements limiting such imports are consummated with foreign governments, or (c) the President finds that imports do not disrupt the U.S. market;
- (5) To revise the national security provisions of the Trade Expansion Act to preclude the use of duties or tariffs whenever the President has determined that imports of a particular product or material are threatening to impair the national security;
- (6) To strengthen the independent status of the U.S. Tariff Commission; and
- (7) To make various other changes in our tariff and trade laws which will streamline the procedures dealing with specific import or export problems.

TRADE AGREEMENT AUTHORITY

The President's trade agreement authority under the Trade Expansion Act of 1962 terminated at the close of June 30, 1967. The President has been without such authority since that time and in his trade message to the Congress, of November 18, 1969, he requested renewal of the authority, including new authority to reduce duties.

The committee amendment would extend the President's authority to enter into new trade agreements under the Trade Expansion Act of 1962 to July 1, 1975. The President is given new authority to reduce duties by 20 percent, or 2 percentage points, below the rates of duty which will exist when the final stage of the Kennedy Round reduction

becomes effective on January 1, 1972. The committee amendment would limit the President's authority to enter into and carry out new trade agreements to those situations in which compensatory concessions are necessary to offset the effects of an increase in U.S. duties or imposition of other restrictions by the U.S. Government on the products of a foreign country which were bound under a trade agreement. Should reductions in duty under the new authority be agreed to prior to the final stages of the Kennedy Round, the remaining stages of Kennedy Round reductions and the new reductions agreed to are to be aggregated and made effective in at least two stages.

OTHER PRESIDENTIAL AUTHORITY

Concern has been expressed about the barriers to trade which have developed despite the Kennedy Round of trade negotiation. In 1962, the Committee on Finance added section 252 to the Trade Expansion Act to provide new authority and direction to the President to act against import restrictions or other acts of foreign countries which unjustifiably or unreasonably burden or discriminate against U.S. commerce. The Trade Act of 1970 broadens the President's authority to deal with foreign trade barriers and streamlines the procedures for handling specific complaints.

The Trade Act of 1970 also amends the President's authority to safeguard the national security by providing that any adjustment of imports under the national security authority shall not be accomplished by the imposition or increase of any duty or of any fee or charge having the effect of a duty. In addition, time limitations are imposed on the Director of the Office of Emergency Preparedness in making determinations on applications for action under the national security provision.

TARIFF ADJUSTMENT AND ADJUSTMENT ASSISTANCE

The need for making less rigid the criteria for determining serious injury from increased imports is met in title III both for tariff adjustment for industries and adjustment assistance in the case of firms or groups of workers.

Tariff Adjustment.—In present law, the criteria for determining serious injury are the same for tariff adjustment for industries and for adjustment assistance for firms and workers. The committee agrees with the House and the Administration that the present criteria are too stringent. Under the new provisions, the Tariff Commission, in the case of tariff adjustment, or the President, in the case of adjustment assistance, is to determine whether increased imports "*contribute substantially*" toward causing or threatening to cause serious injury. In the case of tariff adjustment, the committee provided that increased imports must be related in whole or in part to the duty or other customs treatment reflecting tariff concessions agreed to by the United States.

If serious injury is found to an industry, those Commissioners finding injury are to make an additional determination under the new provision. This additional determination will be in the affirmative if the Commission finds that imports of the article are: (1)

acutely or severely injuring a domestic industry or (2) threatening to acutely or severely injure a domestic industry.

A majority of the Commissioners present and voting is to be required for an affirmative injury determination and a majority of those Commissioners finding injury under the criteria provided must determine the type of import restriction required to remedy the injury.

When the Commission finds and reports to the President an affirmative injury determination, the President is required to take such action as he deems necessary to prevent or remedy the injury so found unless he determines that such action is not in the national interest. In the case of an additional affirmative determination by the Commission on the question of acute or severe injury, the President is required to impose the import restrictions found by the Commission to be necessary to prevent or remedy the acute or severe injury unless he determines that such action would not be in the national interest. As is presently provided, if the President does not make effective the remedy determined by the Tariff Commission, he must report to the Congress within 60 days of the receipt of the Tariff Commission's report and findings. In such case, the existing provisions of law with respect to Congressional implementation of the Tariff Commission finding as to the action necessary to prevent or remedy the injury would continue to apply.

Section 352 of the Trade Expansion Act with regard to orderly marketing agreements is amended to provide that the President may, at any time, negotiate such agreements on articles subject to tariff adjustment or upon which he has received an affirmative injury determination.

New review procedures on pending tariff adjustment action are provided. In any report by the Tariff Commission reviewing such tariff adjustment actions, it must include information on steps taken by firms in the industry to compete more effectively with imports. In addition, in any review of tariff adjustment actions by the Tariff Commission, as a result of which the President may determine to extend, in whole or in part, or terminate such action, the Commission will be required to determine whether the existing restrictions on imports are sufficient to prevent or remedy injury to the domestic industry.

Adjustment Assistance.—The Trade Act of 1970 also revises the procedures for petitions by firms or groups of workers to provide that petitions by firms or groups of workers are to be made to the President rather than the Tariff Commission. The Tariff Commission will continue to provide the President with a factual report to assist the President in making his determination as to eligibility of firms and groups of workers to apply for adjustment assistance.

The amendment provides increased trade adjustment allowances payable to adversely affected workers. Under existing law, the allowance is 65 percent of the worker's average weekly wage or 65 percent of the average weekly manufacturing wage, whichever is lower. The amendment increases each of these percentages to 75 percent.

The amendment provides that if the President does not provide tariff adjustment for an industry after an affirmative injury determination by the Tariff Commission, he is required to provide that the firms and workers in that industry may request certification of eligibility for adjustment assistance.

The Committee also provided the Tariff Commission with a period of 90 days after the date of enactment of this Act to make the necessary changes in its rules and regulations and to so organize its staff to expeditiously process the tariff adjustment and adjustment assistance petitions filed under the provisions of this Act. No new petition may be filed under section 301(a) of the Trade Expansion Act until the Tariff Commission issues new rules and regulations, which must be within 90 days after enactment.

QUOTAS ON CERTAIN TEXTILE AND FOOTWEAR ARTICLES

We believe that the tariff adjustment amendments described above will be sufficient to deal with competitive situations facing many domestic producers in the economy. However, the effects of rapidly increasing imports on two basic industries are such as to require extraordinary measures. Part B of title III of this bill deals with the extremely serious threat to the textile and apparel industry and to the nonrubber footwear industry.

Under part B of title III, the total quantities of imports of certain textile and footwear articles are to be limited by category and by country beginning in the year 1971. For that year, imports are to be limited to the annual average quantities imported during the three calendar years 1967 through 1969. For the years after 1971, the total quantity of imports of each category of textile articles or footwear articles is to be limited to the quantity determined for the foreign country for the preceding year plus an increase determined by the President. Any such increase is to be limited to a percentage not over 5 percent of the total quantity permitted to be entered in the immediately preceding year as the President determines to be consistent with the purposes of the quota provisions.

The President is authorized to exempt from quotas imports of articles: (1) which he determines are not disrupting the U.S. market, (2) when he determines that the national interest requires such action, or (3) when he finds that the supply of such articles in the domestic market is insufficient to meet demand at reasonable prices.

In addition, the President is authorized to negotiate agreements under which imports of textiles and footwear would be controlled on a voluntary basis. Imports covered by such agreements would also be exempt from quantitative limitations as would imports of cotton textile articles as a result of the existing Long Term Arrangements on Cotton Textiles.

Determinations with respect to the establishment of or change in quantitative limitations or exemptions from such limitations, other than determinations made by the President for national interest reasons, would be subject to the rulemaking provisions of the Administrative Procedure Act.

The quota limitations provided in the bill would terminate on July 1, 1976, unless the President finds that the extension of the quantitative limitations for periods not to exceed 5 years would be in the national interest.

OTHER TARIFF AND TRADE PROVISIONS

The magnitude and the nature of U.S. foreign trade has changed remarkably over the past decade. Although both imports and exports separately account for about 4 percent of the gross national product, they now exceed \$80 billion. The committee is concerned that the rules of competition governing this volume of trade be fair to all concerned. Consequently, the committee has tightened the domestic procedures with respect to such international trade practices as dumping and subsidization of exports. Greater recognition as to the role of the Tariff Commission as an independent agency is emphasized in amendments made to the Tariff Act of 1930. The committee directs the Executive and the Tariff Commission to conduct a series of studies aimed at developing basic principles of free and fair trade, insuring reciprocity for U.S. commerce, and fair international labor standards. Provision is also made for the solution of specific trade problems which cannot be remedied under existing provisions of law.

ANTIDUMPING ACT OF 1921

The Antidumping Act is amended to provide that the Secretary of the Treasury must take initial action within 4 months after the question of dumping has been presented to him. In exceptional cases the Secretary would have an additional 90 day period to reach such a finding, if he published in the Federal Register, within 60 days after the complaint is received, the reasons why additional time is absolutely necessary. Under the committee amendment, this would require the withholding of appraisement within that period should the Secretary of the Treasury have reason to suspect that sales at less than fair value are, or are likely to be, taking place. Should the Secretary of the Treasury's initial action involve a tentative negative determination, the Secretary would be authorized to withhold appraisement within three months after the notice of negative determination has been made if he should reverse his initial negative determination. In addition, the Antidumping Act is amended to provide criteria for a determination of dumping with regard to imports from State controlled economies. The amendment reflects existing Customs practices.

COUNTERVAILING DUTY PROVISION

The countervailing duty provision is amended to require the Secretary of the Treasury to make a determination within 12 months after the question is presented to him as to whether a bounty or grant has been bestowed on imports into the United States.

Under the bill, subsidized duty-free imports are also to be subject to the countervailing duty provisions but only if the Tariff Commission should determine that such subsidized imports are injuring a domestic industry. The countervailing duty provision is also amended to provide the Secretary of the Treasury with discretionary authority with respect to the imposition of a countervailing duty on an article subject to quantitative limitation or subject to agreements under which the volume of exports to the United States is limited. Countervailing duties would be imposed when the Secretary determines that such

limitations are not an adequate substitute for a countervailing duty with respect to the article in question.

TARIFF COMMISSION

In view of the added investigative and statutory burden on the Tariff Commission which will result from this legislation and in view of the concern of the committee to protect the independent nature of the Tariff Commission, the committee provided, in effect, that the Tariff Commission's budget shall be directly appropriated by the Congress (as is the budget of other independent agencies such as the General Accounting Office), and that the Executive shall not have authority to reorganize the Commission. The committee bill also would direct the Tariff Commission to do a number of studies which could lay the groundwork for a fresh approach to U.S. trade problems and agreements.

COMPREHENSIVE STUDIES BY THE PRESIDENT AND TARIFF COMMISSION

There are a number of outstanding problems in the field of international trade which require intensive study. One such problem is the apparent lack of balance and reciprocity in the General Agreement on Tariffs and Trade. The presently constituted GATT agreement contains certain provisions that were written in 1947 when the United States had an overwhelmingly dominant position in world trade. They were designed at that time to put more dollars into the hands of the then war-torn European countries. The international economic positions of Europe, Japan, and the United States have changed so radically since the end of World War II that a new executive agreement incorporating the provisions of commercial reciprocity in all trade and investment matters appears to be desirable. As a first step toward the realization of this goal, the committee's bill authorizes and directs the executive branch and the Tariff Commission to conduct a series of studies dealing with the U.S. position in world trade and the rules under which trading nations can freely and fairly compete in world markets. It would be expected that this series of studies will lead to concrete negotiating proposals to the Congress and ultimately to new agreements and machinery for coping with all trade and investment problems.

FOREIGN TRADE STATISTICS

The committee trade amendment also provides for the collection and publication of U.S. import statistics which will show c.i.f. value and thus include the cost of insurance, freight and other charges associated with c.i.f. value. This is the practice recommended to all countries by the United Nations and the International Monetary Fund for computing balance of trade statistics. Over 100 countries have adopted the so-called *c.i.f.* basis of measuring imports; only the United States and a few other countries use the free on board (*f.o.b.*) system, under which imports are tabulated on the basis of their value at the foreign port. The committee felt that the *c.i.f.* system will be more comparable to the method of publishing import statistics used by most other coun-

tries. Moreover, the committee's bill provides that U.S. exports, which are financed directly by Government grants and credits, should be shown separately from other exports on all monthly statistics which are published by the Department of Commerce.

MISCELLANEOUS TRADE PROVISIONS

The committee trade amendment also would provide certain tariff-rate quota controls on imports of glycine and related products and on mink furskins.

The committee also provided a quarterly allocation of meat import quotas and closes a loophole concerning "prepared" fresh, chilled, and frozen beef and veal. The committee amendment does not extend the meat quota provisions to any other products not currently under quota.

The committee amendment also provides that additional invoice information will be required from foreign shippers for the purpose of statistical classification of imports.

The committee amendment also would reduce the rate of duty on parts of ski bindings.

A new provision of law would authorize the President to impose a suspension of trade with a nation which permits the uncontrolled or unregulated production of or trafficking in certain drugs in a manner to permit these drugs to fall into illicit commerce for ultimate disposition and use in this country.

F. Amendments to Public Assistance Programs and Work Incentive Program

1. AID TO THE AGED, BLIND, AND DISABLED

NATIONAL MINIMUM INCOME STANDARDS FOR THE NEEDY AGED, BLIND, AND DISABLED

The committee bill would establish a national minimum income level for persons who receive cash assistance under federally matched State welfare programs for the needy aged, blind, and disabled. States would be required to provide a level of assistance sufficient to assure persons in these categories a total monthly income from all sources of at least \$130 for a single individual or \$200 for a couple. In the aged category this provision would result in increased assistance for eligible single aged individuals in about 31 States and for eligible aged couples in about 36 States. Concurrently with establishing these national minimum standards for assistance to the aged, blind, and disabled, the committee bill would make persons receiving such assistance ineligible to participate in the food stamp program. In effect, the bill would give needy persons more cash in lieu of food stamps.

PASS-ALONG OF SOCIAL SECURITY INCREASES TO WELFARE RECIPIENTS

Under other provisions of the bill, social security benefits would be increased by 10 percent, with the minimum basic social security benefit increased to \$100 from its present \$64 level. If no modification were made in present welfare law, however, many needy aged, blind, and disabled persons would get no benefit from these substantial increases in social security since offsetting reductions would be made in their welfare grants. To assure that such individuals would enjoy at least some benefit from the social security increases, the committee bill requires States to raise their standards of need for those in the aged, blind, and disabled categories by \$10 per month for a single individual and \$15 per month for a couple. As a result of this provision, recipients of aid to the aged, blind, or disabled, who are also social security beneficiaries, would enjoy an increase in total monthly income of at least \$10 (\$15 in the case of a couple).

DEFINITIONS OF BLINDNESS AND DISABILITY

The committee bill provides for the establishment of nationally uniform definitions of blindness and disability for purposes of the federally matched programs of assistance to the blind and disabled. The definitions adopted are those already applied in the disability insurance program established under title II of the Social Security Act.

The term "disability" would be defined by the committee bill as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months," with further clarification of the meaning of "substantial gainful activity."

The term "blindness" would be defined as "central visual acuity of 20/200 or less in the better eye with the use of correcting lens." Also included in this definition would be the particular sight limitation which is referred to as "tunnel vision."

Under present law each State is free to prescribe its own definition of blindness and disability, and the committee bill would permit States to continue assistance to individuals who are now on the rolls under the existing State definition, but who would not be considered blind or disabled under the new Federal definitions.

PROHIBITION OF LIENS IN THE PROGRAM OF AID TO THE BLIND

The committee bill would prohibit any State from imposing a lien on a blind individual's property as a condition of his receiving Federally-matched Aid to the Blind welfare payments. Present law leaves the matter of liens up to the discretion of the States.

FISCAL RELIEF FOR THE STATES

The committee bill includes a provision which generally would not require States in future years to spend more for assistance to the aged, blind, and disabled than 90 percent of their expenditures for this purpose in calendar year 1970. The 10 percent savings would be paid from Federal funds as would the full amount of any increased expenditures resulting from mandatory provisions of the bill (such as the \$10 pass-along of social security increases and the \$130 national minimum standard for assistance to the aged, blind, and disabled). Increases in caseloads resulting from normal program growth would also be fully paid for with Federal funds, but increased expenditures resulting from liberalizations in State welfare programs not required by Federal law would not be covered by the 90 percent limitation. Such optional State liberalizations would be financed in accord with the regular Federal-State matching provisions.

2. CHILD CARE

Although present law includes provisions designed to make child care services available to needy families with children, these services are still unavailable to many who need them. The lack of child care is particularly serious for those who wish to participate in work or training programs, or who undertake employment in an effort to become economically independent. The committee bill would promote the development of additional services both by providing for more favorable matching to the States for child care services and by establishing a new mechanism for the delivery of these services, the Federal Child Care Corporation.

FEDERAL MATCHING SHARE

The bill provides for an increase from 75 percent to 90 percent in the Federal matching share for child care services provided by the States under title IV part A of the Social Security Act. The Secretary of Health, Education, and Welfare would be authorized to pay 100 percent of the cost of child care for a limited period of time in cases where he determined that necessary care would otherwise be unavailable. The 90 percent matching rate would be available to the States for child care for families receiving Aid to Families with Dependent Children and also for past and potential recipients, if the State has adopted the optional program for these groups. States would be required to maintain their present efforts so that additional Federal funds would result in expanded child care services.

FEDERAL CHILD CARE CORPORATION

As a mechanism to expand the availability of child care services, the bill would establish a Federal Child Care Corporation. The Corporation would have as its first priority making available child care services to children of parents eligible for such services under the AFDC program and who need them in order to participate in employment or training. However, it would also have the broader function of making child care available for any family which may need it, regardless of welfare status.

The bill provides for \$50 million as initial working capital for the Corporation. This amount would be in the form of a loan by the Secretary of the Treasury and would be placed in a revolving fund. The money would be used by the Corporation to begin arranging for child care services. Initially, the Corporation would contract with existing public, private nonprofit, and proprietary facilities to serve as child care providers. To expand services, the Corporation would also give technical assistance and advice to organizations interested in establishing facilities under contract with the Corporation. In addition, the Corporation could provide child care services in its own facilities.

Fees would be charged for all services provided or arranged for by the Corporation. The fees would go into the revolving fund to provide capital for further development of services and to repay the initial loan. They would be set at a level which would cover the costs to the Corporation of arranging child care.

The bill also includes a provision which authorizes the Corporation to issue bonds for construction if, after the first two years of operation, the Corporation feels that additional funds for capital construction of child care facilities are needed. Up to \$50 million in bonds could be issued each year, with an overall limit of \$250 million on bonds outstanding. Construction is to be undertaken only if child care services cannot be provided in existing facilities.

Federal child care standards are specified in the amendment to assure that adequate space, staff and health requirements are met. In addition, facilities used by the Corporation would have to meet the Life Safety Code of the National Fire Protection Association. Any facility in which child care is provided by the Corporation, either di-

rectly or by contract, would have to meet the Federal standards, but would not be subject to any licensing or other requirements imposed by States or localities.

The Corporation, while providing a mechanism for expanding the availability of child care services, would not provide funds to subsidize child care. Those who are able to pay would be charged the full cost of services. The cost of child care needed by families on welfare would be paid by State welfare agencies.

State welfare agencies would be free to use the services of the Corporation in providing child care to welfare recipients, but would not be required to do so.

The Corporation would also have the authority to conduct programs of in-service training, either directly or by contract.

The bill requires the Corporation to submit a report to each Congress on the activities of the Corporation, including data and information necessary to apprise the Congress of the actions taken to improve the quality of child care services and plans for future improvement.

The Corporation would be headed by a Board of Directors consisting of three members, to be appointed by the President with the consent of the Senate. The members of the Board would hold office for a term of three years.

A National Advisory Council on Child Care would be established to provide advice and recommendations to the Board on matters of general policy and with respect to improvements in the administration of the Corporation. The Council would be composed of the Secretary of Health, Education, and Welfare, the Secretary of Labor, the Secretary of Housing and Urban Development, and 12 individuals, appointed by the Board.

3. IMPROVEMENTS IN THE WORK INCENTIVE PROGRAM

The Work Incentive Program was created by the Congress as a part of the Social Security Amendments of 1967. It represents an attempt to cope with the problem of rapidly growing dependency on welfare by providing welfare recipients with the training and job opportunities needed to help them become financially independent.

Experience under the program has shown that a number of modifications are desirable. The committee's bill is designed to strengthen and improve the program.

ON-THE-JOB TRAINING AND PUBLIC SERVICE EMPLOYMENT

A major criticism of the present Work Incentive Program has been the lack of development of on-the-job training and public service employment. On-the-job training and public service employment offer the best opportunity for employment of welfare recipients because they provide training in actual job situations. Unfortunately, less than two percent of the welfare recipients enrolled in the Work Incentive Program today are participating in on-the-job training and public service employment. The committee amendment would require that at least 40 percent of the funds spent for the Work Incentive Program be used for on-the-job training and public service employment.

The committee bill would also simplify the financing and increase the Federal share of the cost of public service employment (formerly called special work projects) by providing 100 percent Federal funding for the first year and 90 percent Federal sharing of the costs in subsequent years (if the project was in effect less than three years, Federal sharing for the first year would be cut back to 90 percent).

TAX INCENTIVE FOR HIRING WIN PARTICIPANTS

As an incentive for employers in the private sector to hire individuals placed in employment through the Work Incentive Program, another feature of the amendment would provide a tax credit equal to 20 percent of the wages and salaries of these individuals. The credit would only apply to wages paid to these employees during their first 12 months of employment, and it would be recaptured if the employer terminated employment of an individual during the first 12 months of his employment or before the end of the following 12 months. This recapture provision would not apply if the employee became disabled or left work voluntarily. (The tax credit is described more fully in Part H of this summary.)

REGISTRATION OF WELFARE RECIPIENTS AND REFERRAL FOR WORK AND TRAINING

Under present law, all "appropriate" welfare recipients must be referred by the welfare agency to the Labor Department for participation in the Work Incentive Program. Certain categories of persons are statutorily considered inappropriate. Persons may volunteer to participate in the Work Incentive Program even if the State welfare agency finds them inappropriate for mandatory referral.

Another criticism of the program has been that the State application of those standards of "appropriateness" for the program have resulted in widely differing rates of referrals and program participation. The committee's bill would eliminate this situation with a series of amendments. First, it would require welfare recipients to register with the Labor Department as a condition of welfare eligibility unless they fit within one of the following categories:

1. Children who are under age 16 or attending school;
2. Persons who are ill, incapacitated or of advanced age;
3. Persons so remote from a WIN project that their effective participation is precluded;
4. Persons whose presence in the home is required because of illness or incapacity of another member of the household; and
5. Mothers with children of preschool age.

At least 15 percent of the registrants in each State would be required to be prepared by the welfare agency for training and referred to the Work Incentive Program each year; States failing to meet this percentage would be subject to a decrease in Federal matching funds for aid to families with dependent children. The committee bill would also establish clear statutory direction in determining which individuals would receive employment or training by generally requiring the Departments of Labor and Health, Education, and Welfare to accord

priority in the following order, taking into account employability potential:

1. Unemployed fathers;
2. Dependent children and relatives age 16 or over who are not in school, working or in training;
3. Mothers who volunteer for participation; and
4. All other persons.

Thus, under the amendment, mothers would not be required to participate until every person who volunteered was first placed.

LIBERALIZED FEDERAL MATCHING FOR TRAINING

The committee bill increases from 80 percent to 90 percent the rate of Federal matching for WIN training expenditures. Welfare agency expenditures for social, vocational rehabilitation, and medical services which are provided to directly support an individual's participation in WIN would also be matched at the 90 percent rate. Under existing law, these services are now generally matched by the Federal Government at the 75 percent rate.

LABOR MARKET PLANNING AND PROGRAM COORDINATION

The committee bill would require the Secretary of Labor to establish local labor market advisory councils whose function would be to identify present and future local labor market needs. The findings of these councils would have to serve as the basis for local training plans under the Work Incentive Program to assure that training was related to actual labor market demands.

The committee also mandates coordination between the Departments of Labor and Health, Education, and Welfare and their counterparts at the local level. The committee bill would require a separate WIN unit in local welfare agencies and joint participation by welfare and manpower agencies in preparing employability plans for WIN participants and in program planning generally.

EARNED INCOME DISREGARD

Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard the first \$30 monthly earned by an adult plus one-third of additional earnings. Costs related to work (such as transportation costs) are also deducted from earnings in calculating the amount of the welfare benefit.

Two problems have been raised concerning the earned income disregard under present law. First, Federal law neither defines nor limits what may be considered a work-related expense, and this has led to great variation among States and to some cases of abuse. Secondly, some States have complained that the lack of an upper limit on the earned income disregard has the effect of keeping people on welfare even after they are working full-time at wages well above the poverty line.

The committee bill would deal with both of these problems by modifying the earnings disregard formula and by allowing only day care as a separate deductible work expense (with reasonable limitations on the amount allowable for day care expenses). Under the committee

bill, States would be required to disregard the first \$60 earned monthly by an individual working full-time (\$30 in the case of an individual working part time) plus one-third of the next \$300 earned plus one-fifth of amounts earned above this.

4. FAMILY PLANNING SERVICES

Under present law, family planning services must be offered all appropriate welfare recipients; 75 percent Federal matching is available in meeting the cost of family planning services. The committee bill would provide 100 percent Federal funding for family planning services offered recipients of Aid to Families with Dependent Children. In addition, there would be 100 percent Federal funding, at the State's option, for those who were once welfare recipients or who are likely to become welfare recipients.

5. EMERGENCY ASSISTANCE FOR MIGRANT FAMILIES

The bill would require the States to establish State-wide programs to provide emergency assistance to needy migrant families with children. The Federal matching rate would be 75 percent. Under present law the establishment of programs for migrant families is optional with the States, and the Federal share is 50 percent. As under the existing program, assistance could be in the form of money payments or payments in kind. Assistance would be limited to a period not to exceed 30 days in any 12-month period.

6. OBLIGATION OF A DESERTING FATHER

Present law requires that the State welfare agency undertake to establish the paternity of each child receiving welfare who was born out of wedlock and to secure support for him; if the child has been deserted or abandoned by his parent, the welfare agency is required to secure support for the child from the deserting parent, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. The State welfare agency is further required to enter into cooperative arrangements with the courts and with law enforcement officials to carry out this program. Access is authorized to both Social Security and Internal Revenue Service records in locating deserting parents.

The committee added to these provisions an amendment which would make it a Federal misdemeanor for a father to cross State lines in order to avoid his family responsibilities.

In addition, the committee bill also provides that an individual who has deserted or abandoned his spouse, child, or children shall owe a monetary obligation to the United States equal to the Federal share of any welfare payments made to the spouse or child during the period of desertion or abandonment. In those cases where a court has issued an order for the support and maintenance of the deserted spouse or children, the obligations of the deserting parent would be limited to the amount specified by the court order. If the State has obtained a court order, the Federal Government would attempt to recover both the Federal and non-Federal share of welfare payments to the deserting father's family. If the State has not obtained a court order, the

Federal Government would only attempt to recover the Federal share of the welfare payments. The deserting parent's obligation could be collected in the same manner as any other obligation against the United States.

The bill also would authorize Federal officials knowing the whereabouts of a deserting parent to furnish this information to such parent's spouse (or to the guardian of his child) in cases in which a court order for child support has been issued against him.

7. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING WELFARE STATUTES

DENIAL OF ELIGIBILITY FOR AID TO FAMILIES WITH DEPENDENT CHILDREN WHERE THERE IS A CONTINUING PARENT-CHILD RELATIONSHIP

Under present law, aid to families with dependent children is available to children who have been deprived of parental support by reason of the "continued absence from the home" of a parent. In a recently decided opinion, the Supreme Court ruled that a State could not consider a child ineligible for welfare when there was a substitute parent with no legal obligation to support the child. The Court stated: "We believe Congress intended the term 'parent' in section 406(a) of the act * * * to include only those persons with a legal duty of support."

The committee bill would clarify Congressional intent by permitting States to take into account the presence of a man in the house if there exists between the man and the dependent child a continuing parent-child relationship. For purposes of determining whether such relationship exists between a child and an adult individual, only the following factors could be taken into account:

- (1) They are frequently seen together in public;
- (2) The individual is the parent of a half-brother or half-sister of the child;
- (3) The individual exercises parental control over the child;
- (4) The individual makes substantial gifts to the child or to members of his family;
- (5) The individual claims the child as a dependent for income tax purposes;
- (6) The individual arranges for the care of the child when his mother is ill or absent from the home;
- (7) The individual assumes responsibility for the child when there occurs in the child's life a crisis such as illness or detention by public authorities;
- (8) The individual is listed as the parent or guardian of the child in school records which are designed to indicate the identity of the parents or guardians of children;
- (9) The individual makes frequent visits to the place of residence of the child; and
- (10) The individual gives or uses as his address the address of such place of residence in dealing with his employer, his creditors, postal authorities, other public authorities, or others with whom he may have dealings, relationships, or obligations.

A child-parent relationship could be determined to exist only on the basis of an evaluation of these factors taken together with any evidence which may refute any inference related to these factors.

DURATION OF RESIDENCE REQUIREMENT

The committee bill requires States to impose a one-year duration of residence requirement in determining eligibility for welfare. However, Federal matching would not be denied solely because a State failed to meet this requirement. If a welfare recipient moved to a State with a one-year duration of residence requirement, his State of origin would be required to continue his welfare payments (as long as he remained eligible) for up to 12 months, by which time the individual could establish eligibility for welfare in his new State of residence.

LIMITATION ON DURATION OF WELFARE APPEALS PROCESS

Recently the Supreme Court ruled that assistance payments could not be terminated before a recipient is afforded an evidentiary hearing. The committee bill would require that States reach decisions on an individual appeal within 30 days. The committee bill also requires the repayment of amounts which it is determined a recipient was not entitled to receive. Any amounts not repaid could be considered an obligation of the recipient to be withheld from any future assistance payments to which the individual may be entitled.

STATES PERMITTED TO SEEK TO ESTABLISH NAME OF PUTATIVE FATHER

A recent court decision held that a mother's refusal to name the father of her illegitimate child could not result in denial of aid to families with dependent children (AFDC). The applicable State regulation was held to be inconsistent with the provision in Federal law that AFDC be "promptly furnished to all eligible individuals" on the grounds that the State regulation imposed an additional condition of eligibility not required by Federal law. The Court reached this conclusion despite the explicit requirement in Federal law that States attempt to establish paternity when a child is born out of wedlock.

The committee's bill would clarify congressional intent by specifying that the requirement that welfare be furnished "promptly" may not preclude a State from seeking the aid of a mother in identifying the father of a child born out of wedlock.

REQUIRING WELFARE RECIPIENT TO PERMIT CASEWORKER IN THE HOME

The committee amendment permits States, if they wish, to require as a condition of welfare eligibility that recipients allow a caseworker to visit the home. Home visits would have to be made at a reasonable time and with reasonable advance notice.

8. REGULATIONS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The committee bill would curb the regulatory authority of the Department of Health, Education, and Welfare in several particulars.

"DECLARATION METHOD" OF DETERMINING ELIGIBILITY PERMITTED BUT NOT REQUIRED

The Committee bill would preclude the Secretary of Health, Education, and Welfare from requiring by regulation that States use a simplified declaration method in determining eligibility for welfare. As under present law, States would be free to use this method if they so wished, but they could not be required to do so by regulation.

DEFINITION OF UNEMPLOYMENT

Under present law, Aid to Families with Dependent Children may be paid to a family headed by an unemployed father, at the option of the State (23 States now offer such assistance). However, there is no Federal definition of "unemployment" in the statute. The committee approved an amendment defining a father as unemployed for welfare purposes if he has worked less than 10 hours in the last week or less than 80 hours in the last 30 days.

9. USE OF FEDERAL FUNDS TO UNDERMINE FEDERAL PROGRAMS

The committee added a section to the general provisions of the Social Security Act specifying that no Federal funds may be used to pay, directly or indirectly, the compensation of any individual who in any way participates in Federally supported legal action designed to nullify congressional statutes or policy under the Social Security Act.

10. USE OF SOCIAL SECURITY NUMBERS

The committee bill requires that on and after January 1, 1972, State welfare agencies use the social security number of each welfare recipient as an identification number in the administration of public assistance programs.

11. TESTING OF WELFARE REFORM ALTERNATIVES

The committee bill provides for a broad program of testing of various approaches to reform of the welfare system. The Secretary of Health, Education, and Welfare would be authorized to conduct up to four tests of possible alternatives to the AFDC program. One or two of these tests would involve "family assistance" type programs, and one or two of the tests would involve "workfare" programs. In addition, the bill provides for a pilot project of a program of rehabilitation of welfare recipients to be administered by vocational rehabilitation personnel.

The "family assistance" tests would follow the traditional welfare approach of providing money payments to families with incomes below certain levels, but would extend this assistance to all families with fathers including the so-called "working poor"—low-income families headed by a fully employed male—who are not eligible for AFDC. As under AFDC, a portion of earnings would be disregarded to provide work incentives, and nondisabled adults (with certain exceptions) would be required to accept employment or training.

The "workfare" tests would make a sharp distinction between welfare and "workfare." Families with preschool age children where the father is dead, absent, or disabled would be presumed unemployable and would be eligible for cash welfare payments. Other low income families would not be eligible for such payments but would be guaranteed work opportunity, with training and other preparation for employment where necessary. Participants in these "workfare" programs would have their wages supplemented if they are below the minimum wage. Allowances would also be paid to those in training. Child care and other services would be provided as necessary.

The pilot project to test the administration of welfare programs by vocational rehabilitation personnel would involve assistance payments according to regular AFDC standards. These payments would, however, be administered through the facilities and personnel of the Rehabilitation Services Administration which would also apply its rehabilitation techniques to welfare recipients in an attempt to encourage and assist adult individuals with a potential for work to prepare for and obtain employment.

The various tests would run for a minimum of two years, involve State sharing in costs at a level not in excess of State sharing in the costs of AFDC, and involve continuing consultation among the Department of Health, Education, and Welfare which would conduct the tests, the General Accounting Office, and the Congress. Each test would have to cover all eligible families within a State or a part of a State, and for the duration of the test no AFDC payments could be made to families residing in the test area. Each "family assistance" test would have to run concurrently with a "workfare" test and the two test areas would have to be comparable with respect to various relevant factors including population, per capita income, and unemployment rate.

G. Veterans' Pension Increase

The committee bill incorporates the text of S. 3385, a bill to increase pension benefits to veterans and widows by up to 9 percent. The committee bill would also increase the income limitations, from \$2,000 to \$2,300 in the case of a veteran or widow alone, and from \$3,200 to \$3,600 in the case of a married veteran or widow with a child.

H. Miscellaneous Amendments

1. TAX AMENDMENTS

DENIAL OF TAX DEDUCTION WITH RESPECT TO CERTAIN MEDICAL REFERRAL PAYMENTS

Present law provides that no tax deduction is to be allowed for illegal bribes or kickbacks where, as a result of the payment, there is successful criminal prosecution. If the bribe or kickback does not constitute a criminal act (presumably even if there is a loss of license), or if the taxpayer is not successfully prosecuted, the deduction is allowable.

This provision deletes the requirement in present law of a criminal conviction in the case of bribes and kickbacks before a deduction for such a payment is denied. In lieu thereof, the provision provides that no deduction is to be allowed for a bribe or kickback which is illegal under either Federal or State law, if these laws subject the party involved to liability for criminal or civil penalties (including the loss of license). In the case of a payment which is illegal under State law, the deduction will be denied on the basis of such illegality only if the law is generally enforced. Other sections of this bill provide that medical referral fees under the medicare or medicaid programs are illegal. It is made clear that referral fees are to be treated as bribes or kickbacks for purposes of this provision.

REQUIRED INFORMATION RELATING TO EXCESS MEDICARE TAX PAYMENTS BY RAILROAD EMPLOYEES

Present law provides that a railroad employee whose work is covered by railroad retirement and who is also employed in other work covered by social security is entitled to receive a credit or refund of the excess medicare tax he may have paid because of this dual employment status. To enable a railroad employee to claim his excess medicare tax as a credit on his income tax return, all railroad employers are required to include on the W-2 forms given to their employees, the amount of compensation covered by railroad retirement and the hospital tax deducted.

Because of the inability of most railroads to furnish the required information by January 31 (primarily because of a broader wage concept under railroad retirement) and the fact that only a relatively few employees are eligible for this refund, this provision changes the requirement that railroad employers supply separate hospital tax information on the W-2 forms for all of their employees. In lieu

thereof, the provision requires that railroad employers include on, or with, the W-2 form furnished to its employees, a notice with respect to the allowance of the credit or refund of the tax on railroad-covered wages in those cases where the employee has also received other wages covered under the social security program. Upon the request of an employee, railroad employers are required to furnish to the employee a written statement showing the amount of the railroad tax coverage, the total amount deducted as tax, and the portion of the total amount which is for the financing of the cost of hospitalization insurance under the medicare program.

REPORTING OF MEDICAL PAYMENTS

Present law provides that a person who makes specified kinds of payments in the course of a trade or business to another person, amounting to \$600 or more in a calendar year, must file an information return showing the amount paid and the name, address, and identifying number of the recipient. Although, under this general requirement, persons engaged in a trade or business are required to report direct payments to providers of health care services (often described as "assigned" payments), there is no authority under present law to require the reporting of payments made to patients themselves ("unassigned" payments), even though in the normal circumstances, they are paid over to providers of health care services, or represent reimbursement of earlier payments.

The bill provides specifically, in addition to the general requirement of present law, that all payments in the course of a trade or business made to providers of health care services in the case of direct or "assigned" payments must be reported. Further, in the case of "unassigned" or indirect payments, reporting will be required in those cases where the Federal Government administers the health program or funds the program to a substantial extent. The reporting requirement specifically includes professional service corporations, proprietary hospitals, and other payees who may act as conduits for providers of health care services.

The provision also requires the Secretary of the Treasury and the Secretary of Health, Education, and Welfare to study the extent to which "unassigned" and "assigned" claims are used to obtain payments from insurance organizations and to report each year to the Senate Committee on Finance and the House Committee on Ways and Means any significant shift from the use of "assigned" claims to "unassigned" claims. In addition, the provision requires that the Secretary of Health, Education, and Welfare keep records showing the identity of each provider of medical or health care items or services under the medicare and medicaid programs, the types of items or services provided and the aggregate amounts paid to the providers under each program. Health care providers are required to be identified by their taxpayer identifying numbers. The Secretary of Health, Education, and Welfare must submit to the Senate Committee on Finance and the House Committee on Ways and Means annually a report identifying each person who is paid a total of \$25,000 or more during the preceding year under the medicare and medicaid programs.

These reports are due to be submitted for the calendar year, beginning with 1970, not later than June 30 of the following calendar year.

TAX CREDIT FOR PORTION OF SALARY PAID PARTICIPANTS IN WORK INCENTIVE PROGRAMS

Under present law there are no special tax provisions relating to the costs of employee training programs. These costs are treated as any other business expense and may be deducted if they are ordinary and necessary in carrying on the taxpayer's trade or business.

This provision provides a special tax incentive for employers who hire individuals under a work incentive program (WIN) established under section 432(b)(1) of the Social Security Act. The taxpayer would be allowed, as a credit against his income tax liability, and in addition to his regular business deduction, an amount equal to 20% of the wages and salaries paid to the employee during the first 12 months of his employment. Any unused tax credits could be carried back to the three preceding taxable years (but only to a taxable year beginning after December 31, 1968) and then could be carried forward to the next seven succeeding taxable years.

However, if the taxpayer terminated the employment of the individual at any time during the first 12 months of employment, or at any time during the next 12 months, any tax credit allowed under this provision would be recaptured. The credit would be recaptured by increasing the taxpayer's tax liability, in the year of termination, by an amount equal to previous tax credits allowed with respect to the employee. The recapture provision would not apply if the employee voluntarily left the employment of the taxpayer, or if the employee became disabled. Further, a credit would not be allowed for any expenses of training outside the United States or if the employee is closely related to the taxpayer.

RETIREMENT INCOME CREDIT

Present law provides a retirement income credit of 15 percent of eligible retirement income up to a maximum of \$1,524 for a single person and \$2,286 for married couples where each is fully eligible in his or her own right. The credit is designed to provide comparable tax treatment to those who receive tax-exempt social security benefits and those who receive taxable pensions. Consequently, the maximum base for the credit is reduced by social security benefits received and by earnings in excess of \$1,200—a reduction of 50 cents for each dollar of earnings between \$1,200 and \$1,700 and dollar for dollar for earnings in excess of \$1,700.

Because of increases in social security benefits since the present maximum base for the credit was established, this provision increases the base for the credit to more closely approximate the current levels of social security benefits. It increases the \$1,524 to \$1,872 and the \$2,286 to \$2,808. In addition, the amount that can be earned without reducing the base for the credit is raised from \$1,200 to \$1,680 and the range within which the base is reduced 50 cents for each dollar of earnings is raised to \$1,680 to \$2,880.

2. OTHER AMENDMENTS

The committee also added provisions relating to the authorization of the managing trustee of the social security trust funds to accept gifts made unconditionally to the Social Security Administration, authorizing loans for the installation of sprinkler systems necessary for facilities to meet medicare standards, increasing the grade level of the Commissioner of Social Security, requiring the consent of the Senate to future appointments to the position of Administrator of Social and Rehabilitation Services, and extension of the provision for disregarding certain social security benefit increases under welfare programs.

III. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

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III. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

1. PROVISIONS OF THE HOUSE BILL THAT WERE NOT CHANGED BY THE COMMITTEE

INCREASE IN SPECIAL PAYMENTS TO PEOPLE AGE 72 OR OLDER

(Sec. 102 of the bill)

The bill would increase by 5 percent the special cash payments that are made under present law to people age 72 and older who are not insured for regular cash benefits under the social security system.

Under the 1965 amendments to the social security law, special monthly payments were provided for certain people who reached age 72 before 1969 on the basis of less work than is needed to qualify for regular cash benefits. The cost of the payments under this provision is met out of the old-age and survivors insurance trust fund.

Special monthly payments were also provided, under an amendment to the law enacted in 1966, for persons with no social security credits who reached age 72 before 1968 and for persons who reach age 72 after 1968 and before 1972 who have earned credit for some work but who do not qualify for payments under either the regularly insured or transitionally insured feature in the law. Payments made to the uninsured aged are reduced by the amount of any pension, retirement benefit, or annuity that a person is receiving under any other governmental pension system. Also, the payments are suspended for any month for which the person receives a payment under a federally aided public assistance program. Most of the cost of the payments under this provision is met from general revenues.

Under the increase provided in the bill, the payments under both of these special provisions would be increased by 5 percent, from \$46 to \$48.30 for an individual and from \$69 to \$72.50 for a couple, effective for January 1971. About 6,000 people who do not now get the special payments because they are now getting payments either under another governmental pension system that are as large as the special payment under present law or because they are getting welfare payments would qualify for payments, and about 600,000 people would qualify for higher payments, under this provision.

An estimated \$16 million in additional payments would be paid out in the first full year; about \$14 million of this amount would be paid from general revenues.

The benefit increase would be effective for January 1971. However, like the regular benefit increase—discussed below—the increased amounts would not be paid until April.

LIBERALIZATION OF THE RETIREMENT TEST

(Secs. 105 and 106 of the bill)

Under present law, if a beneficiary under age 72 earns more than \$1,680 in a year, \$1 less in benefits is paid for each \$2 of earnings between \$1,680 and \$2,880 and for each \$1 of earnings above \$2,880. However, full benefits are paid, regardless of the amount of annual earnings, for any month in which the beneficiary neither works for wages of more than \$140 nor renders substantial services in self-employment.

Under the committee bill, a beneficiary would receive the full amount of his benefits each month if his annual earnings did not exceed \$2,000 and his benefit would be reduced by \$1 for each \$2 of earnings above \$2,000.

The committee bill, like the House bill, would increase from \$140 to \$166.66 $\frac{2}{3}$ the amount of wages a beneficiary may earn in a given month and still get full benefits for that month, regardless of his annual earnings. The changes would update the retirement test to take into account the increase in earnings levels since the present \$1,680 annual exempt amount became effective (in 1968) and make possible an increase in annual income for many of the beneficiaries who work.

The bill would also retain the retirement test provision in the House bill that would apply in the year in which a worker reaches age 72. Under present law, benefits are not withheld under the test for months when the person is age 72 or older. However, in the year in which a beneficiary reaches age 72, earnings in and after the month in which he reaches age 72 are counted in determining whether benefits are reduced or withheld for the months before he reached age 72. Many beneficiaries believe that earnings after they reach age 72 are not counted under the retirement test; as a result, they may find that they have been overpaid. The committee bill would provide that only amounts earned before the month in which the beneficiary became 72 would be used in determining his earnings for the year for retirement test purposes. In applying this provision, the earnings of a self-employed beneficiary would be prorated equally to the months in his taxable year.

About 650,000 beneficiaries who will receive some benefits for months in 1971 under present law would receive additional benefits, and about 380,000 persons who would receive no benefits under present law would receive some benefits. Additional benefit payments in the first full year would be about \$404 million.

The provision would be effective for taxable years ending after 1970.

DEPENDENT WIDOWER'S BENEFITS AT AGE 60

(Sec. 107 of the bill)

Under present law, an aged widow can become entitled to widow's insurance benefits at age 60, but an aged dependent widower cannot become entitled to dependent widower's benefits until age 62. The 1965 amendments lowered the age of eligibility for widows from 62 to 60 but did not change the age of eligibility for dependent widowers.

The committee believes that the age of eligibility should be the same for aged dependent widowers as for aged widows. Accordingly, the bill would lower the age of eligibility for aged dependent widower's benefits from 62 to 60. The benefits payable to an aged dependent widower who starts getting benefits before age 62 would be actuarially reduced, as are the benefits under present law for aged widows who come on the benefit rolls before age 62.

Because the benefit amount payable at age 60 would be reduced to take account of the longer period over which benefits would be paid, the payment of these benefits would not result in any additional long-range cost to the program.

APPLICATION FOR DISABILITY BENEFITS AFTER DISABLED WORKER'S DEATH

(Sec. 111 of the bill)

Under present law, an application must be filed with the Social Security Administration to establish entitlement to social security disability insurance benefits by the disabled worker or, if he is unable to file an application, by another person on his behalf. In either event, entitlement to disability insurance benefits cannot be established unless the application is filed during the worker's lifetime.

In most cases a timely application is filed by or on behalf of a disabled worker who meets the other eligibility conditions of the law, so that the benefit rights of both the disabled worker and his dependents are protected. However, in a relatively few cases a disabled worker who would have been eligible for benefits dies before an application is filed and his disability benefit rights are lost. As a result, the living expenses and additional costs incurred by the disabled worker during the period of his disablement may remain unpaid and become obligations of his survivors.

The committee has, therefore, approved the provision of the House bill which would permit disability insurance benefits to be paid if an application is filed within 3 months after the month in which a disabled worker dies. Benefit payments which would have been payable upon application by the disabled worker would then be payable for up to twelve months prior to the month in which an application is filed. An application filed within the extended period would also permit entitlement to dependent's benefits to be established.

The provision would apply in cases of deaths occurring in or after the year of enactment. In cases in which the disabled worker died in the year the bill is enacted but prior to enactment of the bill, an application could be filed within three months after the date of enactment and the application would be deemed to have been filed in the month of death.

PENALTY FOR FURNISHING FALSE INFORMATION TO OBTAIN A SOCIAL SECURITY ACCOUNT NUMBER

(Sec. 114 of the bill)

Under present law, criminal penalties are provided for any person who makes a false representation to obtain payment of social security benefits which are not due him. These penalties may be applied, for

example, if a person attempts to get benefits based on his own earnings under more than one social security number, or to avoid having his benefits withheld under the retirement test by drawing benefits under one number while continuing to work for high earnings under a false name and another number, or to continue to draw disability benefits while engaged in substantial gainful employment under another name and number. Penalties are not provided in the social security law for those individuals who give false information in order to secure multiple social security numbers with an intent to conceal their true identities.

The use of false names, aided by a social security number issued in false names, has led to a number of problems in both private business and the administration of Government programs. Therefore, the bill as passed by the House and approved by the committee would provide criminal penalties if an individual, with intent to deceive the Secretary of Health, Education, and Welfare as to his true identity knowingly and willfully furnishes false information on an application for a social security number for the purpose of obtaining more than one number or of establishing a social security record under a different name. Upon conviction, an individual shall be fined not more than \$1,000 or imprisoned for not more than one year, or both. The penalty would not be applicable, however, if the person obtaining more than one social security number provides sufficient information to permit the Social Security Administration to identify all the numbers issued to such person so that all of his wage credits may be combined.

GUARANTEE THAT NO FAMILY WOULD HAVE ITS TOTAL FAMILY BENEFITS DECREASED AS A RESULT OF AN INCREASE IN THE WORKER'S BENEFIT

(Sec. 115 of the bill)

In the past, when general benefit increases have been enacted, it has been possible in certain cases for a family that comes on the benefit rolls after the increase is effective, and who is entitled to retroactive benefits in the period before the increase is effective, to have its total family benefits decreased slightly below what they would be if the family had been on the rolls in the month before the benefit increase became effective. A decrease of this sort can also occur when a worker's benefit is increased as a result of a recomputation of his benefit to include additional earnings. The decreases occur in cases where the family maximum provision applies and the worker's benefit is actuarially reduced (because it started before age 65).

A special provision was included in the 1969 amendments to prevent a decrease in total family benefits from occurring under the general benefit increase that was included in those amendments. But the provision was only temporary in effect—it applied only to the general benefit increase under the 1969 amendments, and did not apply to recomputations required in the future because the beneficiary had additional earnings.

The bill includes a provision under which no family would have its total family benefits decreased because of an increase in the worker's benefit resulting from a recomputation of the worker's benefit to include additional earnings. (The 10-percent increase in the maximum family benefits provided under the committee bill will avoid any decrease in family benefits as a result of the general benefit increase.)

2. PROVISIONS OF THE HOUSE BILL THAT WERE MODIFIED BY THE COMMITTEE

SOCIAL SECURITY CASH BENEFITS

(Sec. 101 of the bill)

Since the Social Security Act first became law, the Congress has taken action a number of times to assure that benefit levels remain realistic and adequate. Their adequacy has been evaluated in the context of changes in the cost of living, changes in earnings levels, and changes in living standards. Most recently, a 15-percent across-the-board benefit increase was included in legislation approved by the Congress last year, with the increase applicable to benefits payable beginning January 1970.

The committee recommends that social security benefits be further increased across the board by 10 percent, effective January 1971. This contrasts with the 5-percent increase provided in the House bill. The committee bill would modify or eliminate a number of provisions in the House bill affecting select groups of beneficiaries; a portion of the funds provided for these special benefits in the House bill would pay part of the cost of providing an across-the-board increase of 10 percent for social security beneficiaries.

Another major change included in the committee bill would provide a \$100 minimum primary insurance amount—the amount paid when benefits start at age 65 or later—compared with a \$64 minimum under present law and a \$67.20 minimum benefit under the House bill.

Under the present law, monthly benefits for workers who retire at age 65 in 1971 will range from \$64 to \$193.70; under the House-passed bill these amounts would range from \$67.20 to \$203.40; under the committee bill the amounts would range from \$100 to \$213.10. Additional illustrations of the monthly benefits payable under present law, under the House-passed bill, and under the committee bill are shown in the table below.

ILLUSTRATIVE MONTHLY BENEFITS PAYABLE UNDER PRESENT LAW, UNDER THE HOUSE BILL, AND UNDER THE COMMITTEE BILL

Average monthly earnings ¹	Worker ²			Couple ^{2,3}			Widow-mother and 2 children		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill	Present law	House bill ⁴	Committee bill
\$76 ⁵	\$64.00	\$67.20	\$100.00	\$96.00	\$100.80	\$150.00	\$96.00	\$100.80	\$150.00
\$113 ⁵	90.60	95.20	100.00	135.90	142.80	150.00	135.90	142.80	150.00
\$150.....	101.70	106.80	111.90	152.60	160.20	167.90	152.60	160.20	167.90
\$250.....	132.30	139.00	145.60	198.50	208.50	218.40	202.40	208.50	222.70
\$350.....	161.50	169.60	177.70	242.30	254.40	266.60	280.80	280.80	308.90
									0
\$450.....	189.80	199.30	208.80	284.70	299.00	313.20	354.40	354.40	389.90
\$550.....	218.40	229.40	240.30	327.60	344.10	360.50	395.60	395.60	435.20
\$650.....	⁶ 250.70	263.30	275.80	⁶ 376.10	395.00	413.70	⁶ 434.40	434.40	482.70
\$750.....	(⁷)	⁶ 283.00	⁶ 295.80	(⁷)	⁶ 424.50	⁶ 443.70	(⁷)	⁶ 474.40	⁶ 517.70

¹ Figured generally over 5 less than the number of years elapsing after 1936 or 1950, or age 21, if later, and up to the year of death, disability, or attainment of age 65 for men (62 under the House bill for those on the rolls and those who come on in the future; 62 for those who reach age 62 in 1973 or after with the years graded in for men who reach age 62 in 1971 and 1972 under the committee bill) and 62 for women.

² For a worker who is disabled or who is age 65 or older at the time of retirement and a wife age 65 or older at the time when she comes on the benefit rolls.

³ Survivor benefit amounts for a widow-mother and 1 child or for 2 parents would be the same as the benefits for a man and wife.

⁴ For families already on the benefit rolls who are affected by the maximum benefit provisions, the amounts payable under the bill would in some cases be somewhat higher than those shown here.

⁵ Under present law, and under the House bill, average monthly earnings of \$76 or less result in a minimum benefit; under the committee bill, average monthly earnings of \$113 or less result in a minimum benefit.

⁶ Generally payable to people who retire at age 65 in 2006.

⁷ Not applicable, since the highest possible average earnings is \$650.

Some 25.7 million beneficiaries on the rolls in January 1971 would have their benefits increased under this provision. An estimated \$5 billion in additional benefits would be paid in the first full year.

The benefit increase would be effective for January 1971. However, because of the time required to make the changes in the Social Security Administration's records and procedures needed to pay the increased benefits, the first check at the higher rates would be for next March, payable in April. In addition, a separate check covering the retroactive increase for January and February would also be issued in April.

INCREASE IN MAXIMUM FAMILY BENEFITS

(Secs. 101 and of 131 the bill)

Ever since 1940, when monthly benefits were first provided for dependents and survivors, there has been a limitation on the total monthly benefits payable to a family on a worker's earnings record. The purpose of the limitation is to relate family benefits to the approximate take-home pay of the worker. The limitation—the so-called family maximum—is related to the worker's average monthly earnings under the program; under present law it is 80 percent of the first \$436 of average monthly earnings (two-thirds of the maximum possible average monthly earnings—\$650 under the \$7,800 contribution and benefit base), plus 40 percent of the next \$214 of average monthly earnings, but not less than $1\frac{1}{2}$ times the primary insurance amount.

The committee believes that the effect of the family maximum provisions when there is a benefit increase results in certain inequities which should not be allowed to continue. Under the present law, the family maximum is related to a worker's average earnings, which do not change when benefits are increased. Therefore, it has been necessary to provide, with each across-the-board benefit increase, assurance that families on the benefit rolls do not lose benefits and that the family as a whole will get increased payments. The way this has been done in the past has created a situation in which people on the benefit rolls when a benefit hike becomes effective get an increase while people in identical circumstances who come on the rolls in the next month do not. For example, a 3-person family who was on the benefit rolls prior to the effective date and which was getting a maximum family benefit of \$300 a month would have had its total benefits increased under the House-passed bill to \$315 a month. But a family with the same number of beneficiaries whose benefit was based on the same average earnings as the first family, but who came on the rolls a few days later, would have the total benefit limited by the family maximum, which would not have been changed. The family, therefore, would get only \$300 a month. This situation should not occur and the committee bill would adopt a new policy of treating families who come on the rolls after the benefit increase in the same way that families on the rolls before the increase are treated.

Thus, the committee bill provides (in the benefit table and in the section relating to cost-of-living increases) that families coming on the rolls after a benefit increase is enacted, as well as families already on the rolls at the time the increase is enacted, would be guaranteed the full amount (10 percent under the committee bill) of the current and future

general benefit increases. Under the committee bill, maximum family benefits would range from 1.5 to 1.88 times the worker's benefit amount payable at age 65. The level-cost of the change would be 0.04 percent of taxable payroll.

The provision would be effective January 1, 1971.

COST-OF-LIVING INCREASES

(Sec. 131 of the bill)

The committee has revised the House-passed provisions which would provide for automatic increases in social security benefit levels, the tax base and the exempt amount under the retirement test. The committee bill stresses the predominant role of Congress in determining when economic and social conditions have changed so as to require a change in benefit levels (and related changes in tax levels and in the retirement test exempt amount). Under the committee bill, Congress would retain the primary role in determining benefit levels with the automatic provisions serving as a back-up to assure that in the absence of Congressional action, the real value of benefits would not be seriously eroded by rising prices. In addition, the cost of any automatic benefit increases would have no effect on the financial and actuarial status of the social security trust funds.

The House-passed bill would require the Secretary of Health, Education, and Welfare to determine each year, on the basis of the average Consumer Price Index for the third calendar quarter, whether the rise in the Index was sufficient, under the terms of the bill, to cause an automatic increase in benefits for the following January. In October or November—which might very well be after Congress had adjourned—the Secretary would announce his findings. Under the terms of the House-passed bill an increase would be forthcoming only when the Consumer Price Index had risen by at least three percent. An increase in the retirement test exempt amount would be based on the increase in average earnings taxable for social security. The cost of these automatic increases would be met through automatic increases (not more often than every other year) in the social security tax base, based on increases in average taxable earnings.

The committee bill would provide that when the cost-of-living, as measured by the Consumer Price Index, went up benefits would be increased as follows:

1. the first base period would be the Consumer Price Index for January 1971 and a new base period (the second quarter of the year preceding the year in which there is a cost-of-living increase in benefits and—in the case of any legislated increase—the effective month of the legislated increase) would be established after each subsequent benefit increase;

2. each year the Secretary of Health, Education, and Welfare would compare the Consumer Price Index for the base period with the average index for the second calendar quarter and if the index had risen by at least 3 percent, he would promulgate regulations increasing benefits for the following January, and subsequent months, by the same percentage as the rise in the price index;

3. except that no such automatic increase would take effect for a year if in the preceding year the Congress had acted to:

- A. Change the schedule of tax rates, or
- B. Change the tax base, or
- C. Provide a general increase in benefit levels.

In addition, the exempt amount under the retirement test would be increased according to the rise in average wages taxable for social security purposes.

The cost of these automatic increases would be met by increases in tax rates and the tax base. Under the committee bill, each time there was an automatic cost-of-living increase in benefits, social security taxes would be increased to meet the full cost of the increase.

Each time there was an automatic increase the Secretary of Health, Education, and Welfare would be required to determine the full cost—under the 75-year-level-cost procedures used in estimating the long-range cost of the cash benefits program—of the automatic increases and to promulgate, effective for the same month that the benefit increase was effective, new tax rates and a new tax base. An integral part of such promulgation would be a full and detailed explanation of the actuarial assumptions and methodology used in arriving at the new tax rates and the new tax base. In setting the tax rates and the tax base, the Secretary would be required to increase the tax rates so as to provide approximately 50 percent of the additional revenue required with the remaining 50 percent being derived from an increase in the tax base. In recognition of the practical difficulties which might come up in making this division, the Secretary would be authorized to round the tax base increase to the nearest multiple of \$300 and the employee and employer rates, each, to the nearest five one-hundredths of one percent (one-tenth of one percent for the combined employer-employee rate).

The committee bill would require that the Secretary promulgate benefit increases, and consequent tax base and tax rate increases, by August 15. Inasmuch as this requirement, which is three months earlier than under the House-passed bill, was adopted in order to provide time for Congress to consider whether the automatic increases should go into effect or some other action should be taken, it is the committee's intention that the Secretary inform the Congress early in the quarter whenever he determines that an automatic increase will take place.

The committee wishes to make clear its intention that the full cost (as estimated at the time the increase is promulgated) of each automatic increase is to be financed by additional taxes imposed at the same time that benefits are increased and that no part of any calculated actuarial surplus could be used to meet any part of the cost of any automatic increase. For example, if at the time an automatic cost-of-living increase is in order the cash benefits program has an estimated actuarial surplus of 0.05 percent of taxable payroll and the cost of the benefit increase is estimated at 0.40 percent of taxable payroll, the cost of the increase is to be financed by increasing the tax base to a level that, on a long-range basis, will provide excess income approximately equal to 0.20 percent of taxable payroll and by increasing for every year into the future the combined employer-employee tax rate by approximately 0.20 percent and preserving the

calculated actuarial surplus of 0.05 percent of taxable payroll. The Committee regards the Secretary's role as one with no discretion over the amount of the increase in the tax base or the tax rate. His role is simply to perform the actuarial calculations necessary.

It is estimated that under these automatic provisions the social security tax base might rise by an average of about \$750 a year and that the combined employer-employee tax rates might rise by an average of 0.01 percent a year.

INCREASE IN WIDOWS' AND WIDOWERS' INSURANCE BENEFITS

(Sec. 103 of the bill)

When social security benefits were first provided for widows by the Social Security Amendments of 1939 they were set at 75 percent of the worker's retirement benefit. This percentage was based on the idea that a widow should receive one-half of the combined benefit which would have been paid to her and her husband had both been entitled to benefits. Later, this amount was increased to 82.5 percent, where it has remained up to the present.

It is the committee's opinion that an aged widow should not receive less than the amount which was or would have been paid to her husband as retirement benefits. Currently, the average benefit for an aged widow is \$103 a month, while the average benefit for a retired worker is \$118. In addition, surveys of social security beneficiaries have shown that, on the average, women getting aged widow's benefits have less income (other than social security) than most other beneficiaries.

The committee bill would provide an increase in the benefits of widows and widowers who become entitled to benefits after reaching age 62. Under the bill, the benefit for a widow who becomes entitled to widow's benefits at or after age 65 would be increased from the 82½ percent payable under present law to 100 percent of the amount her deceased husband would receive.

Both the House bill and the committee bill are intended to provide benefits to a widow equal to the benefits the widow's deceased husband was receiving or would have received. In certain cases, however, the House bill would actually provide higher benefits to a widow than those her deceased husband was receiving; the committee bill would modify the House provision so that this would not occur.

Under present law, the House bill, and the committee bill, if a worker applies for retirement benefits before reaching age 65 his benefits are actuarially reduced. For example, a man whose earnings record would entitle him to monthly benefits of \$150 at age 65 will receive \$135 monthly if he begins receiving benefits 18 months before his 65th birthday.

Under the House bill, the widow's benefits—if they begin at age 65—would be 100 percent of the benefits her deceased husband would have been eligible for if he retired at age 65—even if he was actually receiving less than this at the time of his death. Using the example cited above, the widow would receive monthly benefits of \$150—11 percent more than her husband received monthly. Under the committee bill, she would receive \$135.

Under the committee bill, a widow whose benefits start at age 65, or after, would receive 100 percent of her deceased husband's primary insurance amount (the amount he would have been entitled to receive if he began his retirement after age 65) or, if his benefits began before age 65, the lower amount he would have been receiving if he were alive.

Under the committee's bill and under the House bill the benefit for a widow or widower who comes on the rolls between 60 and 65 will be reduced (in a way similar to the way widow's benefits are reduced under present law when they begin between ages 60 and 62) to take account of the longer period over which it will be paid. For example, the benefit amount for a widow becoming entitled to widow's benefits at age 63 would be 88.6 percent of her husband's age-65 benefit; for a widow becoming entitled at age 64, the amount would be equal to 94.3 percent of her husband's age-65 benefit.

Under the bill, the benefit amount for January 1971 for a widow (or widower) who came on the benefit rolls before 1971 will be re-determined as though the new provisions had been in effect when she came on the rolls. Thus the widow already on the rolls who started getting benefits before she reached age 65 will have the 100-percent widow's benefit reduced to take account of the longer period for which she will be paid benefits. In order to facilitate the administrative determination of the benefit amount that the deceased spouse would have been receiving if he were alive, the Social Security Administration will assume that his benefits were based on the same average monthly earnings which determine the primary insurance amount on which the widow's (or widower's) benefits are based for January 1971.

Under the bill, as under present law, the benefit for a widow who is age 62 or older when she starts getting benefits and who is the only survivor getting benefits would not be less than the minimum benefit (\$100 under the committee bill) payable to a retired worker at age 65. If the widow starts getting benefits before she reaches age 62, her benefit would be actuarially reduced to take account of the additional period during which she will be receiving benefits.

The 10-percent increase in benefits with the new minimum of \$100 and the changes in the benefit provisions for widows would result in an increase from \$103 to \$136 in the average benefit payable to a widow—\$33 more than under present law.

About 2.7 million widows (and widowers) on the benefit rolls in January 1971 would receive additional benefits; about \$649 million in additional benefits would be paid in the first full year.

The provision would be effective for January 1971. However, due to the time needed by the Social Security Administration to make the needed recomputations, the increased payments would be made, retroactively, later in the year.

AGE 62 COMPUTATION POINT FOR MEN

(Sec. 104 of the bill)

Under present law, retirement benefits for men are figured differently, and less advantageously, than are benefits for women. For a man the period for determining the number of years of earnings that is used in figuring the average monthly earnings on which his benefit

is based ends with the beginning of the year in which he reaches age 65. For a woman the period ends with the beginning of the year in which she reaches age 62. Thus, 3 more years are used in computing benefits for a man than are used for a woman of the same age. This difference in the treatment of men and women can result in significantly lower benefits being paid to a retired man than are paid to a retired woman with the same earnings.

For example, take the case of a man and a woman each of whom reaches age 65 and retires in 1971, and each of whom has maximum creditable earnings under the program in each year up to 1971. The woman's benefit would be \$200.30 a month under present law, while the man's benefit would be only \$193.70 a month. If both workers reach age 62 in 1971, the woman's benefit would be \$155 a month while the man's benefit would be only \$148.80 a month.

The bill would change the way a man's retirement benefit is figured to make the computation the same as the computation of a woman's benefit. As a result, the benefits for most men would be higher than under present law and higher benefits would be paid to the dependents of retired men and to the survivors of men who die after age 62.

Under the House bill, the reduction in the number of years of earnings taken into account would apply both to persons presently receiving benefits and also to future beneficiaries. The committee bill differs by applying the new provision prospectively only, and by providing a 3-year transition period. Under the committee bill, the number of years used in computing benefits for men will be reduced in 3 steps so that men reaching age 62 in 1973 or later would have only years up to age 62 taken into account in determining average earnings. Men who reach age 62 in 1972 would have only years up to age 63 taken into account; men who reach age 62 in 1971 would have only years up to age 64 taken into account.

Consistent with this provision of the committee bill, the House-passed bill would also be modified to provide a 3-step reduction in the number of quarters of coverage needed for insured status for men making the ending point age 62 for both men and women, and thus allow men to become fully insured on the basis of less covered employment than is now required. The first step in this reduction would be effective for January 1971 with subsequent reductions becoming effective in 1972 and 1973.

Due to the change in the insured status requirement for men, about 2,000 persons—workers, dependents, and survivors—not eligible for benefits under present law would be able to claim benefits in the first full year.

Additional benefits of about \$6 million would be paid during the first full year, under this provision.

PAYMENT OF DISABILITY BENEFITS TO BLIND PERSONS

(Sec. 109 of the bill)

The committee's bill extends the provision of the House bill which would modify the disability insurance provisions to improve cash benefit protection for the blind.

To be insured for disability protection under present law a worker must be fully insured and generally must have a total of 20 quarters

of coverage out of the 40 calendar quarters ending with the quarter in which he becomes disabled. An alternative for workers disabled while young provides that a worker under age 31 is insured if he has quarters of coverage in half the quarters after age 21 and up to and including the quarter of disablement, with a minimum of six quarters of coverage. The House bill would eliminate for blind people the 20-out-of-40 requirement and the alternative for young workers so that a blind person could qualify for disability benefits if he is fully insured. The committee bill would lower the disability insured-status requirements further by providing that a blind person would be insured for disability benefits with six quarters of coverage earned at any time.

In addition to changing the insured-status requirements, the committee bill would change the definition of disability for the blind to permit them to meet the definition regardless of their capacity to work, and to receive disability benefits regardless of whether they work. Under present law, a blind person must be unable to engage in any substantial gainful activity, or if aged 55 or over, unable to engage in substantial gainful activity requiring skills or abilities comparable to those used in previous work, in order to be considered disabled for benefit purposes.

Under present law, disability benefits are not payable after attainment of age 65, but the beneficiary (being fully insured to meet one of the requirements for disability benefits) becomes entitled to old-age benefits. The bill would permit blind persons who have six quarters of coverage to continue to receive disability insurance benefits beyond age 65, and since these are disability benefits rather than retirement benefits they would not be subject to deductions under the retirement test.

The bill would also exclude blind persons from the requirement of present law that disability benefits be suspended for any months during which a beneficiary refuses without good cause to accept vocational rehabilitation services.

About 225,000 persons—blind workers and their dependents—would become immediately eligible for monthly benefits. About \$240 million in additional benefits would be paid during the first full year.

The provision would be effective January 1971.

WAGE CREDITS FOR MEMBERS OF THE UNIFORMED SERVICES

(Sec. 110 of the bill)

Under present law, social security coverage is provided on a contributory basis for those serving in the uniformed services in years after 1956, but it is limited to a serviceman's basic pay and does not reflect the cash value of wages in kind, such as food and shelter, which is generally covered under social security with respect to other employment. The 1967 social security amendments, therefore, provided noncontributory wage credits (in addition to the contributory coverage of basic pay), up to \$100 for each month of military service after 1967, to take account of the wages in kind that servicemen receive.

The committee bill, like the House bill, would extend the 1967 provision to cover service during the period 1957-67. This would assure realistic social security credit for service on active duty for

all years that military service has been covered under social security, and would avoid the serious impairment of social security protection that now exists for some workers (and their families) whose benefits are based on only basic pay for years of military service during the period from 1957 through 1967.

In addition, the committee bill would change the way the wage credit is computed. Under present law a serviceman receives a non-contributory wage credit of \$100 for any calendar quarter in which his basic pay was \$100 or less, \$200 for any calendar quarter in which his basic pay was more than \$100 but not more than \$200, and \$300 for any calendar quarter in which his basic pay was more than \$200. In most cases the credit is \$300 a calendar quarter. Under the committee bill, the noncontributory wage credits would be \$300 for every calendar quarter of military service in which the serviceman is paid basic pay.

The committee is advised that this change will result in some slight administrative savings and will expedite the processing of some claims for social security benefits from servicemen and their survivors. The cost of additional social security benefits that would be paid as a result of the enactment of these provisions would be financed from general revenues, on the same basis as the benefits resulting from the present noncontributory wage credits for years after 1967. The additional wage credits would affect approximately 130,000 beneficiaries immediately and result in additional benefits of about \$35 million being paid in the first full year.

POLICEMEN AND FIREMEN

(Sec. 112 of the bill)

The Social Security Act contains special provisions concerning coverage of policemen and firemen. In States not named in section 218(p)(1) of the act, the State may not extend social security coverage (under its agreement with the Secretary of Health, Education, and Welfare) to *policemen* who are in positions covered under a State or local retirement system. Coverage is available for *firemen* under a retirement system in States not named in the Social Security Act, but only if (1) the Governor certifies that the overall benefit protection of the group of firemen involved will be improved by their inclusion under social security, and (2) a referendum is held in which a majority of the firemen favor coverage. If a State is named in section 218(p)(1) of the Social Security Act, policemen and firemen under a State or local retirement system may be covered under social security on the same basis as other State and local employees, whose coverage is subject to various conditions designed to safeguard their interests.

The bill as it passed the House would include Idaho in the list of States in which social security coverage may be extended to policemen and firemen on the same basis as to other State and local employees.

Under present law, the provision applies to 19 States, Puerto Rico, and to all interstate instrumentalities. The 19 States which are now included in the provision are Alabama, California, Florida, Georgia, Hawaii, Kansas, Maine, Maryland, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington. The committee modified the House bill by making the provision also applicable to policemen (but not to firemen) in Missouri.

COVERAGE OF CERTAIN HOSPITAL EMPLOYEES IN NEW MEXICO

(Sec. 113 of the bill)

The bill as passed by the House and agreed to by the committee would permit the State of New Mexico to provide social security coverage, under its coverage agreement with the Secretary of Health, Education, and Welfare for employees of certain public hospitals without regard to the provisions of the Social Security Act which specify the conditions under which a State may bring a group of employees under social security coverage.

As a result of a misunderstanding within the State, certain hospital employees were covered under the New Mexico Public Employees Retirement Association for a short period of time, although the coverage was unintended as far as the hospital and the hospital employees were concerned. This period of coverage under the State retirement system presents a serious obstacle to obtaining social security coverage for the employees in question because of the provisions of the Social Security Act that are designed to protect the rights of such employees against the replacement of coverage under a State or local government retirement system by social security coverage. The unusual situation in New Mexico is not the type of situation to which these provisions designed to provide safeguards for retirement system members were directed.

Under the committee bill, the State would have until January 1, 1972, to provide this coverage, rather than until January 1, 1971, as under the House-passed bill.

CHILDHOOD DISABILITY BENEFITS

(Sec. 108 of the bill)

The committee bill, like the House-passed bill, would improve social security protection for people who become totally disabled before reaching an age at which they are likely to be self-supporting. Under present law, a person can qualify for childhood disability benefits if he has been continuously disabled—as defined in the law—since before age 18 and is still disabled when his parent dies or becomes entitled to social security benefits. The committee's bill would permit the payment of childhood disability benefits when the disability begins before age 22, rather than before age 18.

When a dependent son or daughter becomes disabled between ages 18 and 22, he generally continues to be dependent on his parents. The committee believes that it is appropriate and desirable to provide social security benefits to these children should the insured parent die, become disabled, or retire.

The committee added a new provision to the House bill to permit re-entitlement to childhood disability benefits for a person who had been entitled to childhood disability benefits if he becomes disabled again within 7 years after his benefits were terminated because of a period of substantial gainful employment or medical recovery. This new provision would assure a former childhood disability beneficiary benefit protection either as a worker or as a dependent and might remove a disincentive for childhood disability beneficiaries to attempt to become self-supporting. This change would be consistent with present law which provides benefit re-entitlement to disabled widows and widowers if they become disabled again.

The provisions which extend childhood disability benefits for those disabled before age 22 and which permit re-entitlement to childhood disability benefits if a beneficiary becomes disabled again within 7 years after his entitlement to such benefits was terminated would be applicable not only prospectively but also in the case of people who have already met the conditions proposed for entitlement to benefits and would be effective with respect to benefits for months after December 1970. About 13,000 people—disabled children and their mothers—would immediately become eligible for benefits. About \$13 million in additional benefits would be paid out during the first full year.

ADOPTION OF CHILD BY RETIRED OR DISABLED WORKER OR BY A STEP-GRANDPARENT

(Secs. 116 and 132 of the bill)

The committee bill modifies the provision of the House-passed bill relating to benefits for children adopted by disability insurance beneficiaries to provide uniform rules relating to benefits for children adopted by social security beneficiaries.

Under present law, a child (other than a natural child or a step-child) who is adopted by a worker getting old-age insurance benefits can get child's benefits based on the worker's earnings if (1) the adoption took place within 2 years after the worker became entitled to old-age benefits, (2) the child was receiving one-half of his support from the worker for the year before the worker became entitled to benefits, and (3) either the child was living with the worker in or before the month in which the worker filed application for old-age benefits or the worker had instituted adoption proceedings in or before that month. There is no provision in the law for the child to get child's benefits when he is adopted by a worker more than two years after the worker became entitled to old-age benefits.

In contrast, a child who is adopted by a worker getting disability insurance benefits can get benefits regardless of whether he was being supported by the worker when the worker became disabled, and regardless of when the adoption took place, if all of the following requirements are met:

- (1) The adoption took place under the supervision of a child-placement agency;

- (2) The adoption was decreed by a court of competent jurisdiction within the United States;

- (3) The worker resided continuously in the United States for at least 1 year immediately preceding the adoption; and

- (4) The adoption occurred prior to the child's reaching age 18.

Alternatively, if the child was adopted by a worker getting disability insurance benefits within 2 years after the worker began to get benefits, the child can get benefits if either the worker instituted adoption proceedings in or before the month he became disabled or the child was living with the worker in that month.

The committee believes that the above provisions are unnecessarily complex and that the law should be changed so that eligibility of children adopted by retired workers and children adopted by disabled workers would be determined under common rules. At the same

time, the committee believes that benefits for a child who is adopted by a worker already getting old-age or disability benefits should be paid only when the child lost a source of support when his parent retired or became disabled, and that the law should include safeguards against abuse through adoption of children solely to qualify them for benefits. The committee has included in the bill a provision that it believes will accomplish these objectives.

Under the provision added to the bill by the committee, benefits would be payable to a child who is adopted by an old-age or disability insurance beneficiary if the following conditions are met:

(1) The child lived with the worker in the United States for the year before the worker became disabled or entitled to an old-age or disability insurance benefit;

(2) The child received at least one-half of his support from the worker for that year;

(3) The child was under age 18 at the time he began living with the worker; and

(4) The adoption was decreed by a court of competent jurisdiction within the United States.

A child who was born in the one-year period during which he would otherwise be required to have been living with and receiving one-half of his support from the beneficiary would be deemed to meet the "living-with" and support requirements if he was living with the beneficiary in the United States and receiving at least one-half of his support from the beneficiary for substantially all of the period occurring after the child was born.

Under the present law, a child's social security benefits end when he is adopted unless he is adopted by: (1) a brother or sister, (2) a stepparent, (3) a grandparent, or (4) an aunt or uncle.

Under the present interpretation of the term "grandparent," when a child is adopted by his grandparent's spouse (a step-grandparent) the child's benefits are terminated. On the other hand, if he is adopted by the grandparent, or the grandparent joins in the adoption by the step-grandparent, the child's benefits are not terminated. The committee bill would remove this distinction by adding a step-grandparent to the list of named relatives who may adopt a child without causing his benefits to end.

The provision would be effective January 1, 1971.

3. PROVISIONS ADDED BY THE COMMITTEE

WAITING PERIOD FOR DISABILITY BENEFITS

(Sec. 127 of the bill)

The committee's bill adds a new provision which would reduce the waiting period for disability insurance benefits by two months. Under present law, entitlement to monthly disability benefits cannot begin until a worker has been disabled for 6 consecutive full calendar months. For example, if a worker becomes disabled on January 10, the waiting period is the 6 full months February through July, and his first month of entitlement to benefits is August. (No benefit is payable, however, unless the disability is expected to last, or has lasted, at least 12 consecutive months or to result in death; this latter provision

would not be changed by the committee's bill.) The Department of Health, Education, and Welfare informed the committee that: about one-fourth of the workers in private industry are covered under State temporary disability programs which provide protection during the early stages of long-term disability but do not provide benefits for longer than 26 weeks, less than 2 percent of workers with long-term total disabilities received workmen's compensation, and many workers who have protection against loss of income due to sickness or disability under employer plans (such as group policies, sick-leave plans, or union-management plans) lose their benefits well before the 6th month of total disability.

The committee's change is intended to relieve the financial hardship that occurs when a worker becomes disabled and the family is without earnings during the 6-month waiting period. Therefore, the committee's bill would reduce the waiting period by two months, so that entitlement to disability benefits would begin after a four-month waiting period.

About 140,000 people—disabled workers and their dependents and disabled widows and widowers—would be able to receive a benefit for January 1971 as a result of this provision. Virtually all of these persons would become eligible for benefits for February or March 1971 under present law, upon completion of the 6-month waiting period. About \$185 million in additional benefits would be paid out during the first full year.

The provision would be effective January 1, 1971.

IMPROVE COVERAGE OF U.S. CITIZENS WHO RETAIN RESIDENCE IN THE UNITED STATES AND ARE SELF-EMPLOYED OUTSIDE THE UNITED STATES

(Sec. 121 of the bill)

Under present law, social security coverage of self-employment performed by a U.S. citizen outside the United States is subject to major restrictions because coverage is governed by provisions which were designed to define liability for income tax. In computing earnings from self-employment, a U.S. citizen who retains his residence in the United States but who is present in a foreign country or countries for 510 days (approximately 17 months) out of 18 consecutive months, must exclude the first \$20,000 of earned income for income tax and social security purposes.

Some self-employed U.S. citizens—e.g., free lance newspapermen or news commentators—work outside the United States for long periods at a time before returning to the United States. Such citizens usually had social security coverage before they went abroad. The interruption or reduction of their coverage, because they must exclude their earned income up to \$20,000 a year, in some instances has an adverse effect on the social security protection of the worker and his family.

The committee's bill provides that for social security purposes U.S. citizens who are self-employed outside the United States and who retain their residence in the United States will compute their net earnings from self-employment in the same way as those who are

self-employed in the United States; that is the present exclusion for income tax purposes will no longer apply with respect to the self-employment tax.

The provisions in the committee's bill would not affect the exclusions taken by U.S. citizens who have established thier residence in a foreign country. The committee has included in the bill a provision which will assure that an individual who has established his residence in a foreign country may not obtain social security coverage under the amendment.

The provision would be effective for taxable years beginning after 1970.

EXCLUSION FROM COVERAGE OF CERTAIN EMPLOYEES OF THE STATE OF NEBRASKA

(Sec. 122 of the bill)

The committee added a provision to the House bill which would permit Nebraska to modify its social security coverage agreement with the Secretary of Health, Education, and Welfare so as to remove from coverage two types of services—services of students employed by the public school, college, or university which they are attending, and the services of employees of the State or a political subdivision in part-time positions. Nebraska could have excluded both types of services at the time it provided social security coverage for employees of State or local governments, but did not do so. There are valid reasons for excluding from coverage employees in these two categories, and the State now wishes to exercise the option it could have made at the time social security coverage was provided for State and local government employees. However, under present law it cannot do so without terminating the coverage of all employees in the affected group.

Under the bill, Nebraska could exclude these two types of employment by modifying its coverage agreement with the Secretary of Health, Education, and Welfare before January 1, 1973.

COVERAGE OF CERTAIN EMPLOYEES OF GUAM

(Sec. 123 of the bill)

No employees of the Government of Guam are covered under social security. (Employees of private employers in Guam have been covered since 1960 on the same basis as workers in the U.S.)

There are about 1,500 employees of the Government of Guam, classified as temporary employees who are not covered under social security and who are excluded from coverage under the government retirement system. As a result, they have no protection under any government retirement system. Under present law, social security coverage can be provided for these employees only if it is provided for employees covered under the Government of Guam retirement system. The Government of Guam has requested that coverage be provided for temporary employees who are excluded from coverage under the government retirement system.

The committee's bill would add a provision to cover on a compulsory basis the services of temporary employees (except hospital patients employed by the hospital or prisoners employed by the prison) of the Government of Guam who are excluded from coverage under any retirement system established by the Governments of the United States or Guam. Services performed as members of the Legislature of Guam or as an elected official could not be covered under this amendment.

The provision would be effective for services performed after 1970.

RETROACTIVE PAYMENT OF DISABILITY BENEFITS

(Sec. 130 of the bill)

Under a 1967 Senate amendment certain disabled people were allowed to establish a period of disability—the so-called disability freeze—even though the period provided in the law for filing effective applications had terminated. This 1967 provision was designed to protect a limited number of people who when the disability program was new had been so severely disabled that they did not have the opportunity or ability to file an application.

The committee has been informed that these people also lost benefits which would otherwise have been paid. Therefore, the committee bill would provide for the payment of cash disability benefits for periods of disability prior to 1968 that have been established under the 1967 amendment prior to the enactment of the Social Security Amendments of 1970.

WIDOWS WHO REMARRY

(Sec. 129 of the bill)

Under the present law, when a woman getting widow's benefits marries, her benefit is reduced to the amount that would have been paid to her as a wife or, if the man she marries is entitled to old-age benefits, to the amount of the wife's benefit based on his earnings when a higher amount is payable. While this provision is generally satisfactory, it results in a financial hardship, and perhaps a deterrent to marriage, when a widow marries a retired person who is not entitled to social security or any other public pension. To reduce this financial hardship and obstacle to remarriage, the committee bill would permit a widow who remarries to continue to receive her full widows' benefit when she marries a man who is not entitled to—and who if he had reached eligibility age would not be entitled—a social security benefit or to any other public retirement benefit.

The provision would be effective January 1, 1971.

REFUND OF SOCIAL SECURITY TAX TO MEMBERS OF CERTAIN RELIGIOUS FAITHS OPPOSED TO INSURANCE

(Sec. 128 of the bill)

Since the enactment of the Social Security Amendments of 1965, members of certain religious sects, who have conscientious objections

to social security by reasons of their adherence to the established tenets or teachings of the sect, may be exempt from the self-employment tax provided they also waive their eligibility for social security benefits. This exemption is not available, however, for "employees" covered by the social security tax. The exemption was written largely to relieve the Old Order Amish from having to pay the social security tax when, because of their religious beliefs, they would never draw social security benefits.

As indicated above, the 1965 amendment applies only to members of a religious sect who are self-employed; it does not apply to members of the same sect who work as employees. The report of the Finance Committee in 1965 makes clear that this distinction was intended. It reads in part:

"The proposed exemption would be limited to the self-employment tax under social security since those persons for whom the payment of social security taxes appears to be irreconcilable with their religious convictions also, by reason of their religious beliefs, limit their work almost entirely to farming and to certain other self-employment."

In the interval since the 1965 amendment was enacted, an increasing number of members of the Amish sect have become employees. To some extent this is a result of the unavailability of farm land in areas where they reside. In large measure, in the past, the Amish have confined their labors to agricultural pursuits.

In recognition of the changing pattern of employment the committee concluded that it was appropriate to extend similar treatment for employees to that now available only in the case of the self-employed.

Under this provision, an employee who receives wages where the social security tax is deducted may, if the "authorization" under this provision applies, obtain a credit or refund of this tax.

To obtain this treatment, the individual must file an application for the authorization for credit or refund of the social security tax. To qualify for this authorization:

- (1) the individual must belong to a religious sect, which conscientiously objects to the acceptance of benefits under private or public insurance plans;

- (2) it must be the practice of the sect to make provision for dependent families which is reasonable in view of their general standard of living; and

- (3) the sect must have been in existence at all times since December 31, 1950.

Additionally, for the refund or credit to be available the individual involved must be a member of a sect (or a division thereof) referred to above and an adherent of the established tenets or teachings of the sect (or division), and the Secretary of the Treasury may require such evidence of this as he deems necessary.

It should be clear that the allowance of a credit or refund for the employee's portion of the social security tax does not involve any forgiveness of the employer portion of the social security tax.

In order to give effect to this waiver a provision is added to Social Security Act (section 202(v)) making it clear that where such a waiver has been filed, no benefit payments are to be made with respect to the wages or self-employment income of such individual and no pay-

ments are to be made to him on the basis of the wages or self-employment income of any other person so long as the individual's authorization remains effective.

Finally, the individual must waive his eligibility for social security and medicare benefits (under titles II and XVIII of the Social Security Act) on the basis of his wages and self-employment income or on the basis of the wages and self-employment income of any other person.

The credit or refund is applicable to wages paid for the first calendar year after 1970 throughout which the individual meets the requirements specified above, and in which an application for authorization is filed (except that if an application is filed on or before the date prescribed by law for filing an income tax return for a year the application may be treated as having been filed in the calendar year in which the taxable year begins). The refund or credit ceases to be available in the first calendar year in which the individual ceases to meet the requirements specified above, or the sect (or division thereof) of which the individual is a member, is found by the Secretary of HEW to no longer meet the requirements applicable to it.

INCREASE TRUST FUND MONEY AVAILABLE FOR REIMBURSEMENT OF COST OF REHABILITATING DISABILITY BENEFICIARIES

(Sec. 120 of the bill)

The committee's bill adds a new provision which is intended to increase the number of social security disability beneficiaries who are rehabilitated to a degree that permits them to return to gainful employment. Under present law, the total amount of trust fund money that may be used in any year for reimbursing State agencies for the costs of rehabilitation services provided disability beneficiaries may not exceed 1 percent of the social security disability benefits paid in the previous year. The committee has been informed that increasing the funds available for rehabilitation services should result in an increase in the number of beneficiaries who are rehabilitated. Thus, the bill would increase the trust fund money available for rehabilitation in two steps—to 1.25 percent for fiscal year 1972, and to 1.5 percent for fiscal year 1973 and subsequent years. The Department of Health, Education, and Welfare advised the committee that the savings to the trust funds resulting from this recommended provision will exceed the additional costs of the rehabilitation services.

Prior to enactment of the trust fund reimbursement provision in 1965, the social security disability beneficiary rolls were not a significant source for selection of potential rehabilitants under the regular vocational rehabilitation program since social security disability beneficiaries are generally more severely disabled than other disabled people. The number of social security disability beneficiaries who received rehabilitation services under the trust fund reimbursement provision has grown from 10,462 in 1967 to 32,851 in 1969. The Department estimates that the average value of future benefits that would have been payable to a disabled beneficiary if he had not been rehabilitated amounts to more than \$15,000, or a gross saving of about \$62 million for the more than 4,000 disabled bene-

ficiaries who received rehabilitation services under the trust fund reimbursement provision and who had been removed from the social security benefit rolls through fiscal year 1969. On the basis of experience thus far, it is estimated that there will be a saving to the trust funds of about \$1.60 for every \$1 invested in the rehabilitation program.

The committee has requested the Social Security Administration to make an in-depth examination of its experience under the provision for financing rehabilitation costs from the trust funds and to submit a report of its findings to the Congress prior to January 1, 1972. The report should include comprehensive information on the number and characteristics of beneficiaries receiving rehabilitation services and those reported by State agencies as rehabilitated. The committee is particularly interested in having information as to the status of reported rehabilitations at points of time after rehabilitation, the amount of work they have done, the length of time they have worked, the amounts they have earned, and information about the rate of return of these people to the benefit rolls, including the reasons why, numbers, and percentages. The report should also include estimates of the savings to the social security trust funds resulting from rehabilitation of beneficiaries in relation to trust fund expenditures for rehabilitation purposes, and all other information which would be useful in evaluating the effectiveness of rehabilitating disability insurance beneficiaries.

BENEFITS FOR A CHILD ENTITLED ON THE RECORD OF MORE THAN ONE WORKER

(Sec. 124 of the bill)

Under present law, a child entitled to social security benefits based on the earnings record of more than one worker gets benefits on only one earnings record—the record of the worker that produces the highest primary insurance amount.

In cases where a child is entitled to benefits on the earnings record of more than one worker, the amount of his benefit based on the earnings record of the worker who has the highest primary insurance amount is sometimes smaller than the benefit based on the earnings record of another worker on whose record he is also entitled. He is, however, paid the smaller amount.

This situation can arise because children who are entitled on the earnings record of a retired or disabled worker get a benefit equal to 50 percent of the worker's primary insurance amount, while children entitled on the earnings record of a deceased worker get a benefit equal to 75 percent of the deceased worker's primary insurance amount.

When the present provision was enacted, a child's benefit was always 50 percent of the worker's primary insurance amount, whether the worker was living or dead, so that the highest possible benefit was always the benefit based on the highest primary insurance amount. Subsequent changes increased the surviving child's benefit to 75 percent of the primary insurance amount.

The committee bill would add a provision to the House bill to provide that a child who is entitled to social security child's insurance

benefits on the earnings record of more than one worker will get benefits based on the earnings record which would result in paying him the highest amount, if the payment would not reduce the benefit of any other individual who is entitled to benefits on any of the earnings records on which the child is entitled. (Entitlement of a child on the earnings record that will give the child the highest benefit can result in a reduction of the benefits for others entitled on the same earnings record because of the requirement to keep the total benefits within the family maximum.)

The provision would be effective January 1, 1971.

RECOMPUTATION OF BENEFITS BASED ON COMBINED RAILROAD AND SOCIAL SECURITY EARNINGS

(Sec. 125 of the bill)

A social security beneficiary in a given year may receive benefits based only on earnings in prior years. In order to assure that a beneficiary's social security benefits fully reflect his earnings under the social security system, his primary insurance amount is automatically recomputed from year to year if he has current earnings. When this provision of the Social Security Act was modified in 1967, recomputation was provided for "if an individual has wages or self-employment income for a year after 1965." This wording has inadvertently created a problem in one special type of case involving persons entitled to benefits under both the social security and railroad retirement systems.

A living individual with entitlement to both social security and railroad retirement benefits may receive benefits separately under both systems. If he dies, however, his survivors may receive benefits from only one system based on his combined earnings under both systems. Thus, upon his death a recomputation is necessary. If he retired before 1966 and had no earnings after 1965, the language of the law has been interpreted as preventing the Social Security Administration from automatically recomputing survivor benefits based on combined social security and railroad retirement earnings.

A specific exception in the law is needed to make it clear that survivor's benefits will be based on the worker's combined social security and railroad earnings, as they were under the law in effect prior to the Social Security Amendments of 1967 (and as they are when they are payable under the railroad system).

The committee bill would add a new provision to the House-passed bill to provide that a deceased individual who during his lifetime was entitled to social security benefits and railroad compensation and whose railroad remuneration and earnings under social security are, upon his death, to be combined for social security purposes would have his primary insurance amount recomputed on the basis of his combined earnings, whether or not he had earnings after 1965.

UNDERPAYMENTS

(Sec. 126 of the bill)

Under present law, if a beneficiary dies before receiving all of the social security cash benefits due him, payment may be made only to a

surviving spouse, child, parent, or legal representative of the deceased beneficiary's estate, in that order of priority.

Where there is no surviving spouse, child, or parent and the deceased beneficiary's estate consists of little more than social security benefits due, payment is often not made because some survivors find it too costly to take the action necessary to become the legal representative of the estate. When the present order of priority was under consideration in 1967, the committee added a further category under which underpayments could be paid to persons related to the deceased individual by blood, marriage, or adoption. The Senate change was deleted from the bill by the conference committee. Since then, experience has shown that disposition of underpayments can be made in only about 60 percent of the cases without formal probate proceedings.

The committee's bill would add a provision to the House bill to facilitate the disposition of underpayments of cash social security benefits due a beneficiary who has died.

The new provision would provide that if there is no surviving relative in the categories listed in present law, and no legal representative of the estate, cash benefits due a deceased beneficiary could be paid to any other relative (by blood, marriage, or adoption) of the deceased who may be determined by the Secretary of Health, Education, and Welfare, under regulations promulgated by him, to be the appropriate person to receive the benefits on behalf of the estate.

EMPLOYEES OF THE STATE OF LOUISIANA SERVING AS REGISTRARS OF VOTERS

(Sec. 133 of the bill)

The committee has added a provision to the House bill, applicable only to registrars of voters and employees of the registrars, in the State of Louisiana which would permit the removal of services performed by these workers from social security coverage. About 150 workers are involved.

Under the provision, the registrars and their employees would be given one year—1971—in which to decide if they wished to continue their social security coverage and if by the end of the year they decide that they do not wish to do so, this coverage would be terminated effective January 1, 1973. Thus, the termination of coverage would not be effective for 2 years in accord with the provision of present law that a State cannot terminate coverage of a group of employees until 2 years after it has advised the Secretary of Health, Education, and Welfare of its intent.

4. PROVISIONS OF THE HOUSE BILL THAT WERE DELETED BY THE COMMITTEE

ELECTION TO RECEIVE ACTUARIALLY REDUCED BENEFITS

(Sec. 106 of the House bill)

Under present law, a married person who has worked and is eligible for both an old-age insurance benefit as a retired worker and a wife's or husband's insurance benefit as the spouse of a retired worker cannot apply for just one of the benefits; when she applies for one she is deemed to have applied for both. As a result, such a person who

claims benefits before age 65 has both of his benefits actuarially reduced.

Under the House bill, a person eligible for benefits as a retired worker and also as a spouse could choose to take only one of the benefits and claim the other one later, or she could take both benefits at the same time. Also under the bill the reduction that is made in one benefit would not lower the amount of a benefit that is taken later.

The committee bill would delete the House-passed provision. The purpose of actuarially reduced benefits is to provide some benefits for people prior to regular retirement age without additional cost to the program. If a person could take a benefit based on his own earnings record that was reduced because it was paid before age 65 and later get an unreduced wife's or husband's benefit on the earnings record of a spouse, it would defeat the purpose of the actuarial reduction provision, and add to the cost of the program.

BENEFITS FOR DIVORCED WOMEN

(Sec. 111 of the House bill)

The committee bill retains the provisions of present law which require that in order to qualify for benefits as a divorced wife, divorced widow, or surviving divorced mother a woman must show that (1) she was receiving at least one-half of her support from her former husband, or (2) she was receiving substantial contributions from her former husband pursuant to a written agreement, or (3) there was a court order in effect providing for substantial contributions to her support from her former husband. The House-passed bill would delete these provisions.

Benefits paid to a divorced woman under the social security program are intended to provide a partial replacement of support that is lost when her former husband retires, becomes disabled, or dies. The committee believes that where a divorced woman is not getting alimony or continuing support from her former husband and where there is no written agreement or court order providing for her support the woman does not lose a source of support, or potential support, when her former husband retires, becomes disabled, or dies. The committee believes, therefore, that the support requirements in present law are consistent with the basic principles of the social security program.

DISABILITY BENEFITS AFFECTED BY THE RECEIPT OF WORKMEN'S COMPENSATION

(Sec. 115 of the House bill)

The committee deleted the provision in the House bill which would have raised the ceiling on income from combined workmen's compensation and social security disability insurance benefits from 80 percent to 100 percent of the disabled worker's average current earnings before the onset of his disability. The objective of the offset provisions is to avoid the payment of combined amounts of social security benefits and workmen's compensation payments that would be excessive in comparison with the beneficiary's earnings before he became disabled.

The committee considers it somewhat doubtful that the increased ceiling proposed in the House bill would still meet the objective of the offset provisions.

COVERAGE OF FEDERAL HOME LOAN BANK EMPLOYEES

(Sec. 116 of the House bill)

The committee bill deletes the provision in the House bill that would extend social security coverage to the approximately 500 current employees and all future employees of the Federal Home Loan Banks. The employees are now covered under a staff retirement plan. The Federal Home Loan Bank Board has requested that social security coverage be extended to these employees. The committee believes that social security coverage should not be extended to them without further study of the benefit levels which would result.

IV. MEDICARE AND MEDICAID

Medicare and Medicaid

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IV. MEDICARE AND MEDICAID

1. PROVISIONS OF THE HOUSE BILL THAT WERE NOT SUBSTANTIALLY CHANGED BY THE COMMITTEE

PAYMENT UNDER THE MEDICARE PROGRAM TO INDIVIDUALS COVERED BY FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Sec. 201 of the bill)

Under present law, Federal employees and retirees age 65 and over who are enrolled for Federal employees health benefits (FEHB) are also covered under the medicare hospital insurance plan (part A) if they have worked in employment covered by social security or railroad retirement and are eligible for monthly cash benefits under these programs. In addition, Federal employees, whether or not eligible for part A benefits, may enroll in the medicare voluntary supplementary medical insurance plan (part B) which is available to essentially all persons age 65 and over. Part A hospital insurance protection under medicare is earned during a person's working years through a separate tax on his earnings and no payments are made by those entitled to benefits after they have stopped working. Part B medical insurance protection is available at 50 percent of cost, for which the enrollee pays a monthly premium—currently \$5.30 monthly—matched by the Federal Government.

In contrast, persons who are eligible for health insurance protection under a FEHB plan continue to pay the same premium rates for their coverage after retirement as they did when they were active employees (although the coverage may be more valuable since older people use more medical services). The Federal Government currently pays about 24 percent of the overall cost of FEHB protection, with its share increasing to 40 percent effective January 1, 1971.

When the medicare program was enacted in 1965, it was intended that it would provide basic health insurance protection for people age 65 and over and that it would pay its benefits in full without regard to any other benefits that might be payable under an employee health benefits plan. At the same time, it was expected that such plans would adjust their benefit policies to complement the protection provided under medicare rather than duplicating the benefits.

Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over (active or retired) so that such protection would be supplementary to medicare benefits.

Although most Federal employment covered by a Federal staff retirement system is excluded from social security coverage, many Federal employees become insured under social security on the basis

of other employment. About 50 percent of retired and active Federal employees age 65 and over are entitled to hospital insurance benefits under medicare.

Several problems arise under the present situation. The FEHB plans cover many of the same health care expenses that are covered under medicare. In cases where health care expenses are covered under both medicare and a Federal employee plan, the medicare benefits are paid first, and the Federal employee plan then pays its benefits in an amount which, when added to the benefits payable under medicare, may not exceed 100 percent of the expenses allowable under the FEHB plan.

A Federal employee who is covered under a high-option FEHB plan as well as the medicare plans has somewhat better protection than is afforded under the FEHB plan alone. But, because of the nonduplication clauses in the FEHB contracts, he does not derive the full value of the protection of the FEHB contracts. If a Federal retiree entitled under medicare cancels his enrollment under a FEHB plan because of the high total cost of his health care protection, he will lose the high level of protection he previously enjoyed under the FEHB program at an age where his health care costs can be expected to increase substantially.

Federal retirees and employees who are covered under an FEHB plan generally do not find it advantageous to enroll in the medicare voluntary supplementary medical insurance plan, because of the overlapping of FEHB benefits and benefits under the supplementary plan. Thus, Federal retirees and employees do not receive the advantage, available to virtually all other persons age 65 and over, of the 50-percent Government contribution toward the cost of the protection under the supplementary medical insurance program.

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB, the Finance Committee approves the provision in the House bill which would provide that effective January 1, 1972, the medicare program (both parts A and B) would not pay for any otherwise covered service if such service is covered under a FEHB plan. This provision would not go into effect (or would be suspended, if already in effect) if the Secretary of Health, Education, and Welfare certifies that the FEHB program has been so modified as to assure that there is available to each Federal employee or retiree age 65 and over one or more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare, and the protection of part B alone and that the Government is making a contribution toward the health insurance of each Federal employee or retiree age 65 and over, which is at least equal to the contribution it makes for high option coverage under Government-wide FEHB plans. This contribution could be in the form of a Federal contribution toward the supplementary FEHB protection or a payment to or on behalf of such employee or retiree to offset the cost of his purchase of medicare protection, or a combination of the two. It is the hope and the intent of the committee that the Secretary will be able to make this certification before January 1972.

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT ELIGIBLE UNDER PRESENT TRANSITIONAL PROVISIONS

(Sec. 202 of the bill)

Present law provides hospital insurance protection under the "special transitional provision" for people who are not qualified for cash benefits under the social security or railroad retirement program. (The provision excludes an active or retired Federal employee, or the spouse of such an employee, who is covered or could have been covered under the provisions of the Federal Employees Health Benefits Act of 1959; aliens residing in the United States for less than 5 years; and people who have been convicted of a crime against the security of the United States, including sabotage, espionage, treason, etc.) The "special transitional provision" covers people who are not qualified for cash benefits under the social security or railroad retirement program and who reached age 65 before 1968 even though they had no work under social security (or in the railroad industry). Those who attained or will attain age 65 after 1967 must have had specified amounts of work under these programs in order to be eligible for hospital insurance protection. The transitional provision will phase out as of 1974 as persons attaining age 65 in those years must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

Since the transitional provision is designed to provide hospital insurance coverage for only a part (though a large part) of the uninsured aged and to eventually phase out, a portion of the aged, though small in number (as of January 1, 1970, this portion numbered approximately 305,000 or 1½ percent of the aged population), are and will be, for one reason or another, excluded from hospital insurance coverage. (The 305,000 people include 55,000 recent immigrants, who would continue to be excluded from coverage; 145,000 active or retired Federal employees, who are not eligible under the transitional provision; and 105,000 others.) Although these ineligible include a substantial number of people who were eligible for social security coverage but who did not elect (or whose employers did not elect) to be covered (including employees of State and local governments), they also include several other groups: (1) wives who have never worked under covered employment and whose husbands are eligible for hospital insurance under the transitional provision, (2) women who are not insured on their own account and who cannot qualify for dependent's benefits (such as dependent aged sisters of insured workers and the dependents of uninsured workers), and (3) workers, such as agricultural and domestic workers, whose earnings may have been so low or sporadic they were unable to acquire insured status.

Further, it has become very difficult for many in this group to obtain private hospital insurance comparable to coverage under medicare. Since the passage of the medicare law, private insurance companies have generally changed their hospital insurance plans available to people age 65 and over to make their coverage complementary to medicare. While there is generally some type of hospital insurance available to persons age 65 and over, most of that which is offered is in the form of specified cash payment insurance, paying from \$25 to \$200 per week

for limited periods of hospitalization. Few private health insurance companies offer their regular hospital expense plans to the aged.

The committee agrees with but has made some technical changes in the provision in the House bill which would make available hospital insurance coverage on a voluntary basis to persons age 65 and over, including civil service annuitants and their spouses, who are not entitled to such coverage under existing law. A State or any other public or private organization would be permitted to purchase such protection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed by those who elect to enroll for this protection. Enrollees would pay a monthly premium based on the cost of hospital insurance protection for the uninsured group; such premium would be \$27 a month beginning with July 1971 and up to and including June 1972, and would be recomputed each year and increased in the same proportion as the inpatient hospital deductible. The same restrictions on enrollment and reenrollment (including a 10-percent-per-year charge for late enrollment) would apply as now apply to enrollment for supplementary medical insurance (including the changes in such enrollment provisions made by other provisions in the bill). Aliens who have been in the United States less than five years and persons who have been convicted of certain subversive crimes would be excluded from participation under this provision, just as they are excluded from enrolling for supplementary medical insurance.

The committee's bill also would require that in order for persons to be eligible to enroll for hospital insurance they must be enrolled for supplementary medical insurance. Those persons who have failed to enroll for supplementary medical insurance within the 3-year enrollment limit as prescribed by present law would be able, under another provision in the committee's bill to meet this requirement since they would no longer be excluded from enrolling for supplementary medical insurance. If a person terminates his supplementary medical insurance, his hospital insurance coverage under this provision would be automatically terminated effective the same date as his supplementary medical insurance termination. The committee believes that such a restriction is necessary to reduce the possibility of excessive utilization of the more expensive hospital insurance coverage as might occur if an individual were enrolled for hospital insurance (covering primarily institutional care) but not for supplementary medical insurance (covering primarily outpatient care).

LIMITS ON PREVAILING CHARGE LEVELS

(Sec. 224 of the bill)

Under present administrative policies under medicare, the prevailing limit on the reasonable charge for a service is intended, over the long run, to be generally about the 83d percentile of customary charges for that service in the physician's locality. To illustrate, if customary charges for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was \$150, 40 percent rendered by physicians who charge \$200, 40 percent rendered by physicians who charge \$250 and 5 percent rendered by

physicians who charge \$300 and with the remaining 5 percent rendered by physicians charging in excess of \$300, the prevailing limit would be \$250, since this is the level that would cover at least 83 percent of the cases. However, if 15 percent, rather than 5 percent, of the services were rendered by physicians whose customary charge was at the \$300 level with 5 percent charging above that level, the prevailing charge limit would be \$300, since this would then be the level that would cover at least 83 percent of the cases.

Customary charges for services that are within the prevailing fee limit are generally recognized in full. (In a relatively small number of situations additional rules are used to judge the reasonableness of charges.)

The committee believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned.

Under the committee's bill, the prevailing charges recognized for a locality could be increased in fiscal year 1972 and in later years only to the extent justified by indexes reflecting changes in the operating expenses of physicians and in earnings levels. What the bill provides is a limit on the increases that would be recognized on the basis of the other reasonable charge criteria. Increases in the customary charges of individual physicians and in the charges prevailing among physicians in a locality would continue to be recognized only on the basis of adequate evidence that such increases had been in effect for a period of time. The new ceiling on recognition of increases in prevailing charge limits that is provided would come into play only when the adjustments necessary to meet increases in the actual charges prevailing in a locality exceeded, in the aggregate, the level of increase justified by other changes in the economy.

The Secretary would establish the statistical methods that would be used to make the calculations to establish the limit on the increases allowed by this provision.

The base for the proposed economic indexes would be calendar year 1969. The increase in the indexes that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges above the original base that would be recognized in the fiscal year beginning after the end of that calendar year.

Initially, the Secretary would be expected to base the ceilings for recognition of increases in prevailing fee limits on presently available indexes of changes in consumer prices and earnings combined in a manner consistent with available data on the ratio of the expenses of practice to income from practice occurring among self-employed physicians as a group. If, for example, available data indicated that for self-employed physicians as a group, expenses of practice absorbed approximately 40 percent of gross receipts of practice (the proportions indicated for 1966 by data compiled by IRS from tax returns), the Secretary could determine that the maximum aggregate increase in prevailing charge levels that could be recognized in a carrier area would be 40 percent of the area increase in the BLS Consumer Price Index (all items less medical care) plus 60 percent of the area increase in the

earnings reported to the social security program. The increase in the BLS Consumer Price Index (which includes a service component and other prices reflecting, to some degree, office salaries paid by physicians) would be considered to indicate the justifiable increase in fees to take account of increases in costs met by the physician in his practice and the increase in earnings would be considered to indicate the justifiable increase in fees to keep the physician's earnings in line with the earnings of others. Thus, if during calendar year 1970 the area increase in prices was 3 percent and the area increase in earnings was 5 percent, the allowable aggregate increase in prevailing charges recognized by the carrier in each locality during fiscal year 1972 would be 4.2 percent:

$$(.40 \times .03) + (.60 \times .05) = .042$$

The carrier would apply the prevailing charge criteria now in the law (but setting the prevailing charge limit at the 75th percentile of customary charges rather than at the 83d percentile permitted under present policies) to data on charges in calendar year 1970 to determine the increases in prevailing charges that it would be appropriate to recognize during fiscal year 1972. In the illustration cited earlier, where 20 percent of appendectomies in a locality were rendered by physicians who customarily charged \$300 or more and 80 percent of such services were rendered by physicians customarily charging at or below \$250, the prevailing charge level for that service would be \$250 (the level that would cover at least 75 percent of the cases), rather than the prevailing charge level of \$300 (the level that would cover at least 83 percent of the cases) that would be set under present policies. If the aggregate increase in prevailing charges so determined was less than 4.2 percent, the adjustments would be permitted and the portion of the allowable aggregate increase not used in that fiscal year could be carried forward and used in future fiscal years. However, if the aggregate increase in prevailing charges found otherwise appropriate exceeded 4.2 percent, such increases would be reduced to the extent necessary to bring the aggregate of all increases within the 4.2 ceiling—that is, if the new prevailing charge limits that were indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges multiplied by the frequency of the related services in calendar year 1970 exceeded, in total, the prevailing charge limits indicated for fiscal year 1971 by the 75th percentile of calendar 1969 charges multiplied by the frequency of the related services in calendar 1969 by 8.4 percent, then each of the prevailing charge increases indicated for fiscal year 1972 by the 75th percentile of calendar year 1970 charges would be reduced by one-half so that the aggregate increase allowed would be within the 4.2 ceiling.

It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, the committee believes that the viability of the proposal does not depend on a great deal of further refinement. The objectives of the proposal could be attained with equity through the use of an approach such as that described above. This is so because the indexes are not to be applied on a procedure-by-procedure basis that would raise serious questions of equity in absence of refinements to take account of variations in the mix of factors of production among

various types of medical services and to take account of changes in productivity with respect to various services. Rather, the indexes will operate as overall ceilings on prevailing fee level increases recognized in a carrier area under which adjustments permitted by the present customary and prevailing charge criteria could be made to take account of the shifting patterns and levels of actual charges in each locality. Thus, whether the new limit on prevailing charges will actually affect the determination of reasonable charges depends on the degree to which physicians' fees rise in the future. If the rise in fees in the aggregate was no more than the rise in prices and earnings, the rise in fees would be allowed in full.

The committee believes it desirable to provide the Secretary with appropriate leadtime for implementation of the proposed ceilings on recognition of prevailing charge increases and to provide a conservative base for its application. For this reason, the committee bill includes an interim provision for the remainder of fiscal year 1971 requiring, in effect, an extension of present policies to contain program costs. Under this interim provision the medical charge levels currently recognized as prevailing in a locality could be increased after enactment of the bill and during fiscal year 1971, only to the extent found necessary, on the basis of statistical data and methodology acceptable to the Secretary, to bring the charge levels recognized as prevailing in a locality to the 75th percentile of the customary charges (weighted by frequency rendered) made for similar services in the same locality during calendar year 1969. However, if currently allowed charges exceed this 75th percentile, no decrease in charges would be required by the new legislation. And, as noted earlier, the prevailing charges calculated as representing the 75th percentile in calendar year 1969 will establish the base from which the rate increase in prevailing charge levels will be measured. The economic index that would go into effect starting with fiscal year 1972 would be applied to this base to establish limits in future years.

The committee believes that it is essential to implementation of the original congressional intent that the Department of Health, Education, and Welfare require that in an area where a significant number of payments are made under Blue Shield and other service benefit contracts and to the extent such payments are generally accepted by physicians as payment in full, they should be properly reflected in the charge data used in the determination of reasonable charges. Under these service benefit plans, the participating physician agrees to accept the Blue Shield allowance as payment in full for services to patients with incomes below specified limits. Where the actual number of cases in which the Blue Shield payment represents payment in full is unknown and valid estimates cannot be obtained, reasonable presumption should be drawn from the number and probable income levels of those covered by service benefit contracts and whether such income levels would generally encompass most beneficiaries and as to the number of instances in which the Blue Shield payment would usually represent the physician's full payment.

While relating the allowability of future increases in prevailing charges to general economic indicators is an appropriate method for reasonable charge determinations with respect to the services of physi-

cians, the committee believes it would be inappropriate for reasonable charge determinations with respect to medical supplies, equipment, and services that do not generally vary in quality from one supplier to another. This is so because no program purpose would be served by allowing charges in excess of the lower levels (the comparable House provision referred to "lowest levels") at which supplies, equipment, or services can be readily obtained in a locality. For this reason, the committee bill permits deviation from generally applicable reasonable charge criteria where it is determined that medical supplies, equipment, and services do not generally vary in quality from one supplier to another.

The committee recognizes that it will not be possible for the Secretary to immediately establish special charge or cost limits for every item or service not materially affected in quality by the supplier who actually furnishes it to the patient. However, the committee believes that it is important to make explicit the Secretary's authority and it is expected that he will assert such authority to impose rules for determining reasonable charges when, after due consideration, he determines that a particular item or service does not vary in quality from one supplier to another and devises special rules for reasonable charge determinations that he considers equitable and administratively feasible. Until the Secretary designates an item or service as falling within the scope of this provision and establishes rules for determining reasonable charges for that item, the presently applicable rules, including any special rules imposed by the carrier, would generally remain in effect.

The committee believes that it would be advisable for the Secretary to give priority attention to items of service or equipment most frequently paid for under the program. The committee also believes that there are certain items of service for which special reasonable charge rules can be readily established. Where a separate charge is made by a physician for an injection, for example, the maximum allowance should be a scheduled amount based upon the approximate ingredient and supply cost plus a modest specified amount (such as \$1.00) to cover the injection service. This seems reasonable since an injection generally is not a service requiring a high level of training and experience; paramedical personnel are normally capable of and often provide the service. Similarly, schedules of allowances should be established by geographic or medical service area, where appropriate, for routine laboratory work—including interpretation of results—for tests not ordinarily included in the charge for a physician visit. The scheduled allowance should be based on the costs of tests (including common groupings of tests) when undertaken by qualified efficient and economical sources—such as independent automated laboratories—to which physicians in an area have reasonable access.

While the provision discussed above is directed to items and services that do not generally vary in quality from one supplier to another, the committee notes that present law provides authority for special reasonable charge rules and limits with respect to any item or service for which such special rules are found to be necessary and appropriate. The committee believes that it is reasonable and desirable to limit charges recognized for routine follow-up visits to institutionalized

patients to a reasonable proportion of charges for the initial visit and to limit charges recognized for visits on the same day to a number of patients in the same institution to amounts that are reasonable in relation to the time usually spent and services provided under such circumstances. Of course, such limitations would not preclude individual consideration of requests for higher allowances where such follow-up visits or multiple visits are justifiable as being non-routine.

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs after enactment of the bill may not be made with respect to any amount paid for items and services that exceeds these new limits. This would be consistent with the situation in the present medicaid program.

The medicaid provisions of the Social Security Amendments of 1965 contained nothing which attempted to limit the charges by physicians that States could pay under their medicaid programs. States could and usually did set some type of limits of their own, typically less than usual or customary charges. The Social Security Amendments of 1967 added a new medicaid provision which required that a State plan must provide assurances that "payments (including payment for any drugs under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." On June 30, 1969, HEW issued an interim regulation which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The HEW regulation stipulated that payments to providers would be limited to those received in January 1969, unless payments were below the 75th percentile of customary charges. States whose payment structures provided fees above the 75th percentile of customary charges were required to adjust their payments so that they did not exceed reasonable charges as determined under medicare. The regulation also stipulates that after July 1, 1970, States may request permission to increase fees paid to individual practitioners only if two conditions are met:

(1) The average percentage increase requested above the 75th percentile of customary charges on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or an alternative designed by the Secretary; and

(2) Evidence is clear that providers and the States have cooperatively established effective utilization review and quality control systems.

The proposed amendment is substantially along the lines of the present regulation, and is effective upon enactment.

AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

(Sec. 227 of the bill)

Present law does not provide authority for the Secretary to withhold future payments for services furnished by an institutional provider of services, a physician, or any other supplier who either abuses the program or endangers the health of beneficiaries, although pay-

ment for past or current claims may be withheld on an individual basis where the services are not reasonable or necessary for treatment of illness or injury or where the supplier fails to provide the necessary payment information.

The committee believes it important to protect the medicare, medic-aid, and maternal and child health programs and their beneficiaries from those suppliers of services who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services. Such protection is not now provided under the law. For example, if a physician is found guilty of fraud in connection with the furnishing of services to a medicare beneficiary, there is no authority under present law to bar payment on his subsequent claims so long as the physician remains legally authorized to practice. States can, and some do, bar from medic-aid providers who abuse the program, but they are not now required to do so.

The committee approves the House provision under which the Secretary would be given authority to terminate or suspend payments under the medicare program for services rendered by any supplier of health and medical services found to be guilty of program abuses. The Secretary would make the names of such persons or organizations public so that beneficiaries would be informed about which suppliers cannot participate in the program. The situations for which termination of payment could be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Also, there would be no Federal financial participation in any expenditure under the medicaid and maternal and child health programs by the State with respect to services furnished by a supplier to whom the Secretary would not make medicare payments under this provision of the bill.

Program review teams would be established in each State by the Secretary, following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers utilized in the administration of title XVIII benefits. Both the professional and the nonprofessional members of the program review teams would be responsible for reviewing and reporting on statistical data on program utilization (which the Secretary would periodically provide). Professional members of the program review team would not be responsible for reviewing cases involving overcharging. Only the professional members of the program review teams would review cases involving the furnishing of excessive, inferior, or harmful services in order to assure that only professionals will review other professionals under this provision.

It is not expected that any large number of suppliers of health services will be suspended from the medicare program because of abuse. However, the existence of the authority and its use in even a relatively few cases is expected to provide a substantial deterrent.

Any person or organization dissatisfied with the Secretary's decision to terminate payments would be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

It is not intended that this provision would in any way change the Secretary's present right to withhold payment where necessary payment information is not provided. Nor would the supplier of services

be entitled to a hearing or judicial review with respect to payments withheld under such existing authority.

The provisions relating to title XVIII would be effective with respect to determinations made by the Secretary after enactment of the bill. The provisions relating to titles V and XIX would be effective with respect to items or services furnished on or after July 1, 1971.

ELIMINATION OF REQUIREMENT THAT STATES MOVE TOWARD COMPREHENSIVE MEDICAID PROGRAMS

(Sec. 228 of the bill)

Section 1903(e) of the medicaid statute requires that each State make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance." Under an amendment adopted by the Congress in 1969 (Public Law 91-36), the operation of this provision was suspended for two years, until July 1, 1971, and the date by which the States were to have comprehensive medicaid programs (applying to everyone who meets their eligibility standards with respect to income and resources) was changed from 1975 to 1977.

The committee has been concerned with the burden of the medicaid program on State finances. For example, one State recently cut back on money going to medical schools in order to finance unexpected increases in the cost of medicaid. There is evidence that some States have moved more rapidly in the direction of expanding their medicaid programs, and consequently increasing their costs, because of the influence of section 1903(e).

The committee agrees with the action of the House which removes section 1903(e) from the act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of expansion of the program could then be reconsidered.

DETERMINATION OF REASONABLE COST OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

(Sec. 229 of the bill)

Under present law, as defined in regulations issued by the Secretary, States are required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare. Several States have objected to this requirement, asserting that use of the medicare formula for medicaid reimbursement can result in their paying more than the actual cost of providing inpatient care to those eligible for medicaid. There is nothing in the legislative history which requires that reasonable costs should be defined precisely the same way for both programs and there are reasons why they should not, such as the differing characteristics of the two populations served.

The Committee on Finance approves the provision of the House bill which retains the intent of the original provision— to avoid having hospitals or their private patients subsidize inpatient care for the poor—

by providing for payment of actual and direct costs of inpatient care for medicaid eligibles. The bill would allow the States to develop their own methods and standards for reimbursement thereby giving them flexibility in working out satisfactory payment arrangements with their hospitals. The Secretary could disapprove a State's plan if it is shown to his satisfaction that the method developed by the State would not pay the actual and direct cost of providing care to medicaid eligibles. Reimbursement by the States would in no case exceed reasonable cost reimbursement as provided for under medicare.

The bill would apply the same determination of reasonable costs to maternal and child health programs. The provisions would be effective July 1, 1971, or earlier if the State plan so provides.

AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

(Sec. 230 of the bill)

Under present law, reimbursement under the medicare program is based on the reasonable costs incurred by providers of services (but only for inpatient hospital services under medicaid and the maternal and child health programs) in providing services to individuals covered by these programs. This results, in some cases, in these programs paying higher amounts for services received by covered individuals than such individuals would be charged if they were not covered by these programs, because, in some cases, a provider's customary charges to the general public are set at a level which does not reflect the provider's full costs.

The committee agrees with the House that it is inequitable for the medicare, medicaid, and the child health programs to pay more for services than the provider charges to the general public. To the extent that a provider's costs are not reflected in charges to the public generally, such costs are expected to be met from income other than revenues from patient care—for example, from endowment or investment income. The bill would provide, therefore, that reimbursement for services under the medicare, medicaid, and child health programs could not exceed the lesser of the reasonable cost of such services as determined under section 1861(v) of the Social Security Act, or the customary charges to the general public for such services.

However, the committee believes that it would be undesirable to apply this provision in the case of services furnished by public providers of services free of charge or at a nominal fee. The bill would provide, therefore, that where services are furnished by a public provider of services free of charge or at a nominal charge, the Secretary shall specify by regulation reimbursement based on those elements of costs generally allowed in the determination of reasonable cost that he finds will result in fair compensation for such services. In such cases fair compensation for a service could not exceed, but could be less than, the amount that would be paid under present law.

The committee recognizes that a provider's charges may be lower than its costs in a given period as a result of miscalculation or special circumstances of limited duration, and it is not intended that provid-

ers should be penalized by such short-range discrepancies between costs and charges. Nor does the committee want to introduce any incentive for providers to set charges for the general public at a level substantially higher than estimated costs merely to avoid being penalized by this provision. Thus, the committee recognizes the desirability of permitting a provider that was reimbursed under the medicare, medicaid and child health programs on the basis of charges in a fiscal period to carry unreimbursed allowable costs for that period forward for perhaps two succeeding fiscal periods. Should charges exceed costs in such succeeding fiscal periods, the unreimbursed allowable costs carried forward could be reimbursed to the provider along with current allowable costs up to the limit of current charges.

The committee intends that for purposes of administering this provision, "customary charges" shall mean (1) the charges listed in an established charge schedule (if the institution has only a single set of charges applied to all patients), or (2) the most frequent or typical charges imposed (if the institution uses more than one charge for a single service). However, in order to be considered to be the "customary charge," a charge would have to be one that was actually collected from a substantial number of individuals. A charge set up in name only, perhaps primarily to avoid the effect of this provision, is not intended to determine medicare reimbursement.

The provisions relating to medicare would be effective with respect to services furnished hospitals and extended care facilities in accounting periods beginning after June 30, 1971, and with respect to services furnished by home health agencies in accounting periods beginning after June 30, 1971. Provisions relating to the medicaid and maternal and child health programs would be effective for accounting periods beginning after June 30, 1971.

PAYMENTS TO STATES UNDER MEDICAID PROGRAMS FOR INSTALLATION AND OPERATION OF CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

(Sec. 232 of the bill)

Under present law, States are required to use methods of administration deemed necessary by the Secretary for efficient operation of the program. Federal matching is now set at 50 percent for administrative costs and 75 percent for compensation of professional medical personnel. Despite this requirement, many States do not have effective claims administration or well-designed information storage and retrieval systems; nor do they possess the financial and technical resources to develop them if required to do so by the Secretary.

The committee approves the provision of the House bill which proposes to aid the States in meeting their responsibilities by authorizing 90 percent Federal matching for the cost necessary to the State for it to design, develop, and install mechanized claims processing and information retrieval systems for its own use deemed necessary by the Secretary. The Federal Government acknowledges the obligation to provide technical assistance, including the development of model systems, to each State operating a medicaid program. It is expected that this financial and technical support will aid the States in realizing efficient and effective administration of the program, and that it will reduce program costs.

Your committee also recognizes the importance of this activity by providing Federal matching funds at the 75 percent rate for the operation (including contract operation) of a system approved by the Secretary.

States would not be eligible to receive this increased Federal support until they have developed the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers, the dates on which services were furnished, and the amount of payment made. Experience with the medicare program indicates that beneficiary complaints about discrepancies between the "explanation of benefits" form they receive, and the care actually provided, has been the largest single source of information on possible abuse and fraud. It is appropriate to combine the requirement that States provide such explanations with the increased Federal matching which would support such an activity. Savings resulting from increased administrative efficiency would more than offset the costs of this provision.

This provision of the bill would be effective July 1, 1971.

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

(Sec. 234 of the bill)

Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service. Present law also provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of HEW makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

The committee agrees with, but has made technical changes in, the provision in the House bill which seeks to overcome these difficulties by prohibiting payment for a service where the request for payment is made pursuant to an assignment to anyone other than the physician or other person who furnishes the service, except that the committee has provided that payment may be made, under conditions to be prescribed by the Secretary, to the employer of the physician or other

person if he is required as a condition of his employment to turn over his fees to his employer, or to a facility which is the sole organization which has the right to charge for the service.

The committee's bill would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

This provision as it applies to medicare would be effective with respect to bills submitted and requests for payment made on or after March 1, 1971. For medicaid the provision would be effective July 1, 1971, or earlier if the State plan so provides.

UTILIZATION REVIEW REQUIREMENTS FOR HOSPITALS AND SKILLED NURSING HOMES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

(Sec. 235 of the bill)

Under present medicare law, each hospital and extended care facility is required to have a utilization review committee to review all long-stay cases as well as review, on a sample or other basis, admissions, durations of stay and professional services. The reasons for requiring hospitals and extended care facilities to have utilization review committees for medicare cases apply with equal force to review of medicaid cases, but there is now no such requirement in the medicaid law.

The Committee on Finance approves the House provision which would require hospitals and skilled nursing homes participating in the medicaid or maternal and child health program to have cases reviewed by the same utilization review committee already reviewing medicare cases or, if one does not exist, by a committee which meets the standards established under medicare. It is not intended that where medicaid requires more stringent or comprehensive utilization review than does medicare, such requirements be reduced by virtue of operation of this section. States could, if they wish, impose more stringent requirements; e.g., they might request that the committee review medicaid patient stays earlier than medicare cases since the medicaid population is generally younger than that covered under medicare.

This provision would be effective July 1, 1971.

ELIMINATION OF REQUIREMENT THAT COST-SHARING CHARGES IMPOSED ON INDIVIDUALS OTHER THAN CASH RECIPIENTS UNDER MEDICAID BE RELATED TO THEIR INCOMES

(Sec. 236 of the bill)

Under present law, a State cannot impose deductibles or other cost-sharing devices on cash assistance recipients. In addition, while deductibles or copayments can be imposed with respect to the medically indigent, they must be "reasonably related to the recipient's income and resources."

The Committee on Finance agrees with the House bill which would remove the restriction relating to the medically indigent in order to

allow States to explore the cost advantages that may result from the direct savings and possible decrease in utilization that cost-sharing devices of a specified amount for all the medically indigent might create. Even a small charge gives the recipient a sense of participation and can reduce any tendency toward excessive use of services. Experience with many programs covering prescription drugs has shown that a modest copayment can control excessive utilization. The committee believes that States should have the option of introducing copayment provisions for the purpose of reducing the overutilization of services.

It would be expected that States would impose flat deductibles or copayments primarily with respect to these items of health care or services which are provided in large part at the initiative of the patient. States would be permitted to have such a copayment for such services for all of its medically indigent.

The ban on use of deductibles or copayments for cash assistance recipients would be retained.

This provision would be effective January 1, 1971.

NOTIFICATION OF UNNECESSARY ADMISSION TO A HOSPITAL OR EXTENDED CARE FACILITY UNDER MEDICARE PROGRAM

(Sec. 237 of the bill)

Under present law, the utilization review committee required to function in each hospital and extended care facility must review all long-stay cases and at least a sample of admissions. When in the review of a long-stay case the utilization review committee determines that further stay in the institution is not medically necessary, the committee is required to notify promptly the physician, the patient, and the institution of its finding. No medicare payment is made for any services furnished after the third day following such notification.

The committee approves the provision in the House bill which would require a similar notification, and a similar payment cut-off after 3 days, to be made where the utilization review committee in its sample or other review of admissions finds a case where hospitalization or extended care is no longer necessary (or never was necessary). Thus, the committee's bill would remove the anomaly of continuing payment in a case where the utilization review committee determined in the course of sample or other review that admission to the institution or further stay was not necessary and would make parallel the treatment accorded long-stay cases and cases reviewed on a sample basis.

This provision would be effective with respect to services furnished after the second month following enactment of the bill.

USE OF STATE HEALTH OR OTHER APPROPRIATE MEDICAL AGENCY TO PERFORM CERTAIN FUNCTIONS UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

(Sec. 238 of the bill)

Under present law, one State agency may have the responsibility for certifying health facilities for participation in the medicare pro-

gram and another agency for certifying health facilities for participation in medicaid and maternal and child health programs. The committee believes that this duplication of effort in the verification of and in the establishment and maintenance of health standards is unnecessary and inefficient. The committee's bill would require the State to provide that the same agency shall perform these functions for medicare, medicaid, and the maternal and child health programs. The House bill specified "State health agency" as the responsible State body. However, in some States—such as Louisiana—another agency performs the certification function for medicare. The committee has therefore included a technical amendment to authorize use of the appropriate State medical agency rather than limiting the designation to "State health agency."

The Committee on Finance also believes that the effectiveness and economy of the medicaid program would be enhanced through development of capability in each State to perform utilization reviews, to establish standards relating to the quality of health care furnished to medicaid recipients, and to review the quality of the services provided. Activities such as these would provide information on the under- or over-utilization of resources and the quality and appropriateness of care.

To encourage the development of the capabilities upon which these improvements would be based, the committee bill provides that Federal participation in medicaid payments be contingent upon the establishment of a plan, acceptable to the Secretary, for utilization review, the establishment of standards relating to the quality of care furnished to medicaid recipients, and review of the quality of services provided. Federal matching at the 75-percent rate is now available for the costs of the health professionals and their supporting staff found necessary in carrying out such functions.

This provision would be effective July 1, 1971.

COVERAGE PRIOR TO APPLICATION FOR MEDICAID

(Sec. 251 of the bill)

Under present law a State may, at its own option, cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for medicaid. Thirty-one States have elected to provide this coverage, thereby protecting persons who are eligible for medicaid but do not apply for assistance until after they have received care, either because they did not know about the medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.

The committee agrees with the Committee on Ways and Means and believes that such coverage is reasonable and desirable and recommends that the States be required to provide protection for that 3-month period. Therefore, the committee's bill requires all States to provide coverage for care and services furnished in or after the third month prior to application for those individuals who were otherwise eligible when the services were received.

This provision would be effective July 1, 1971.

HOSPITAL ADMISSIONS FOR DENTAL SERVICES UNDER THE MEDICARE PROGRAM

(Sec. 252 of the bill)

Under present medicare procedures, when a patient is hospitalized in connection with the performance of noncovered dental procedures, payment may be made for inpatient hospital services if the patient has other impairments so severe that hospitalization is necessary. In some cases, intermediaries require that a physician certify to the medical necessity of dental admissions, since hospitalization is ordinarily not necessary for the provision of dental services. Where such a certification is required, the dentist who will be performing the dental procedures must arrange for a physician to make the necessary certification.

The committee approves the provision in the House bill which would authorize the dentist who is caring for the patient to make the determination of the necessity for inpatient hospital admission for dental services without requiring a corroborating certification by a physician. The committee believes that in these kinds of cases the dentist is in a better position to make the necessary evaluation of the patient's condition and probable reaction to dental surgery than is a physician who may not be familiar either with the patient or the nature of the dental procedures to be performed.

This provision would be effective with respect to admissions occurring after the second month following enactment of the bill.

EXEMPTION OF CHRISTIAN SCIENCE SANATORIUMS FROM CERTAIN NURSING HOME REQUIREMENTS UNDER MEDICAID

(Sec. 253 of the bill)

Under present law, Christian Science sanatoriums are permitted to participate in the medicaid program as skilled nursing homes, and as such, are required to meet the general requirements established for skilled nursing homes.

The committee agrees with the House that Christian Science sanatoriums which do not actually provide medical care, should not be required to have a skilled nursing home administrator licensed by the State, to maintain an organized nursing service under the direction of a registered nurse, to maintain detailed medical records, or to have diagnostic and other service arrangements with general hospitals. The bill would, therefore, exempt Christian Science sanatoriums from the requirements for a licensed nursing home administrator and other inappropriate requirements of the medicaid program. Such sanatoriums will be expected to continue to meet all applicable safety standards.

This provision would be effective upon enactment.

EXTENSION OF GRACE PERIOD FOR TERMINATION OF SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WHERE FAILURE TO PAY PREMIUMS IS DUE TO GOOD CAUSE

(Sec. 255 of the bill)

Under present law, an individual's coverage under the supplementary medical insurance part of medicare is terminated for non-

payment of premiums. The termination is effective on a date determined under regulations which may be established so as to provide a grace period (not in excess of 90 days) during which overdue premiums may be paid and coverage continued.

Several types of cases have arisen in which termination of an individual's supplementary medical insurance protection for failure to pay all premiums due within 90 days is clearly inequitable. For example, there have been cases where for reasons of physical or mental incapacity the enrollee was unable to make the premium payment within the allowed time limit and there was no one acting on his behalf to protect his interests. In other cases, coverage has been terminated because the enrollee mistakenly believed that payment had been made when actually it had not.

The Committee on Finance approves the provision in the House bill which would extend the 90-day grace period for an additional 90 days where the Secretary finds that there was good cause for failure to pay the premium before the expiration of the initial 90-day grace period.

This provision would apply to such cases of nonpayment of premiums due within the 90-day period preceding the date of enactment.

EXTENSION OF TIME FOR FILING CLAIM FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS WHERE DELAY IS DUE TO ADMINISTRATIVE ERROR

(Sec. 256 of the bill)

Under present law, a claim for benefits under the supplementary medical insurance program must be filed by December 31 of the year following the year in which the services were provided. (For this purpose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) The present time limit is adequate for the vast majority of supplementary medical insurance claims. In some few cases, however, beneficiaries have failed to file a timely claim due to a mistake or other action on the part of the Government or one of its agents. For example, misinformation from an official source or delay in establishing supplementary medical insurance entitlement has resulted in late filing of claims.

The committee agrees with the House provision which would provide that where a claim under supplementary medical insurance is not filed timely due to error of the Government or one of its agents, the claim may nevertheless be honored if filed as soon as possible after the facts in the case have been established. This provision would assure that claimants would not be treated inequitably because of such an error.

This amendment would apply with respect to bills submitted and requests for payment made after March 1968.

WAIVER OF ENROLLMENT PERIOD REQUIREMENTS WHERE INDIVIDUAL'S RIGHTS WERE PREJUDICED BY ADMINISTRATIVE ERROR OR INACTION

(Sec. 257 of the bill)

Under present law, an individual can enroll in the supplementary medical insurance program during his initial 7-month enrollment

period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year), which begins within 3 years after the end of his initial enrollment period. (The committee's bill includes a provision which would eliminate the 3-year limit on enrollment. That provision is discussed immediately following discussion of this provision.)

There have been some relatively rare cases in which it has been discovered that due to an action, inaction, or error on the part of the Government an individual is in fact enrolled, or is in fact not enrolled, under supplementary medical insurance when both the individual and the Government had until then believed that the reverse was true. Such cases include instances where an individual filed an enrollment request timely 2, 3, or more years ago, but it was inadvertently misfiled, and never acted upon. When the request is discovered, the individual, who did not know he had supplementary medical insurance coverage is presented with a substantial bill for premiums; or if he is a beneficiary, he may find that his benefit check is reduced or withheld altogether to pay premiums for supplementary medical insurance coverage which he never knew he had. Another type of case involves the person who enrolled in good faith and was allowed medical insurance on the basis of evidence showing that he had attained age 65; several years later new evidence is discovered which shows he was only age 64 at the time of enrollment—that is, new evidence shows that he was not eligible to enroll when he did. In such situations the Government is forced to disallow the supplementary medical insurance coverage, refund all premiums received, recover any supplementary medical insurance benefits paid, and notify the person that if he wishes supplementary medical insurance coverage he may enroll in the next general enrollment period. Although these cases are rare, they can cause considerable hardship and distress to the individuals involved, and present law permits no relief to be given.

The committee shares the belief of the Committee on Ways and Means that where an individual's enrollment rights under supplementary medical insurance has been prejudiced because of the action, inaction or error on the part of the Government, he should not be penalized or caused hardship. The bill, therefore, authorizes the Secretary to provide such equitable relief as may be necessary to correct or eliminate the effects of these situations, including (but not limited to) the establishment of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums.

This provision would apply to all cases which have arisen since the beginning of the program but it is not contemplated that the administration be required to conduct an extensive search for cases which arose prior to enactment.

ELIMINATION OF PROVISIONS PREVENTING ENROLLMENT IN SUPPLEMENTARY MEDICAL INSURANCE PROGRAM MORE THAN 3 YEARS AFTER FIRST OPPORTUNITY

(Sec. 258 of the bill)

Under present law, an individual can enroll for the first time in the supplementary medical insurance program during his initial

7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year) which begins within 3 years after the end of his initial enrollment period. A person whose enrollment has terminated may not enroll for the second time in supplementary medical insurance unless he does so in a general enrollment period which begins within 3 years after the effective date of such termination. An individual may reenroll only once.

The 3-year enrollment limit was included in the law (as are other limitations on enrollment in the supplementary medical insurance program) in the interest of avoiding antiselection in case the enrollment under the program was not a very substantial proportion of people eligible to enroll. For example, substantial numbers of people who are relatively healthy might delay enrollment until they are well past age 65 and have become sick, at which point they would enroll and receive substantial benefits without having paid much in premiums. However, since there is now a 95-percent rate of participation in the program and since the vast majority of enrollees enroll at the earliest possible time, there would seem to be no reason to retain the 3-year limit on enrollment. Further, present law provides that premiums for late enrollees are increased 10 percent for each full 12 months elapsed between the time they could have enrolled and actually do enroll and this provision would be retained. Such late-enrollment charges serve to prevent antiselection and to meet the higher costs associated with those who enroll at older ages.

The committee approves the provision in the House bill which would eliminate the 3-year limit with respect to both initial enrollment and reenrollment after an initial termination. Enrollment periods would remain as presently defined and the restriction limiting individuals who terminate enrollment to reenroll only once would be retained.

This provision would apply to all requests for enrollment filed after enactment of the bill.

WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVOR WHO IS WITHOUT FAULT

(Ses. 259 of the bill)

Under present law, an individual to whom (or on behalf of whom) a medicare overpayment is made is subjected to recovery action with respect to such overpayment, except that the recovery action may be waived if the individual is without fault and if recovery would defeat the purposes of the cash social security title (title II) of the Social Security Act or would be against equity and good conscience. If such individual dies, recovery action is initiated as necessary from any other individual who is receiving cash social security benefits on the same earnings record as the deceased overpaid beneficiary. In the latter situation, however, waiver of recovery action is not permitted even though the surviving beneficiary—a widow, for example—is without fault with respect to the overpayment.

The Social Security Amendments of 1967 included a provision which permitted recovery to be waived in the case of cash benefits if the indi-

vidual from whom recovery is being considered is without fault, even though the overpaid individual was at fault. However, the comparable change with respect to medicare overpayments was not made. As a result, there are situations in which, for example, an overpayment made to a deceased beneficiary is the responsibility of his widow even though she was without fault in causing the overpayment, whereas if the overpayment had been made to or on behalf of the widow herself, the waiver provision would apply if she were not at fault.

The committee's bill would rectify this anomaly by permitting any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purposes of title II or would be against equity and good conscience.

The provision would be effective upon enactment for overpayments outstanding at that time.

REQUIREMENT OF MINIMUM AMOUNT OF CLAIM TO ESTABLISH ENTITLEMENT TO HEARING UNDER SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

(Sec. 260 of the bill)

Under present law, people enrolled in the supplementary medical insurance program are assured an opportunity for a fair hearing by the carrier when requests for payment under supplementary medical insurance are denied or are not acted upon with reasonable promptness, or when the amount of the payment is in controversy, regardless of the dollar amount at issue. Experience under the program indicates that the holding of a full fair hearing is unwarranted in cases where the amount in controversy is relatively small. Carriers have reported cases involving \$5 and \$10 claims for which the cost of holding a fair hearing has exceeded \$100. Approximately 45 percent of the hearings held since the beginning of the program have involved an amount less than \$100. Further, regulations require carriers to have a reconsideration review of all denied claims. Such review involves different claims personnel than those who acted on the original claim and should be sufficient protection in small claims cases.

The committee's bill would require that a minimum amount of \$100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

The provision would be effective with respect to hearings requested after the enactment of the bill.

COLLECTION OF SUPPLEMENTARY MEDICAL INSURANCE PREMIUMS FROM INDIVIDUALS ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

(Sec. 261 of the bill)

Under present law, the responsibility for collecting supplementary medical insurance premiums for enrollees entitled to both railroad retirement benefits and social security benefits is vested in either the Social Security Administration or the Railroad Retirement Board, depending upon the circumstances of entitlement at the time of enroll-

ment. This arrangement requires an administrative procedure under which persons so entitled can enroll in the supplementary medical insurance program with either agency. The result has been that some individuals (because all the facts are not made known at the time of enrollment) are enrolled twice and have two different identifying numbers; others are enrolled by the Social Security Administration and not enrolled by the Railroad Retirement Board, or vice versa, and thus may have two medicare cards—one showing entitlement to benefits under part A only and the other showing entitlement to benefits under both parts A and B. Such discrepancies, even though ultimately corrected, are a source of confusion to beneficiaries and a cause of unnecessary administrative expense.

Also, the processing of medical insurance claims is established so as to require that all claims submitted by or on behalf of railroad beneficiaries be handled by a single carrier, presently the Travelers Insurance Company. Because the account numbers assigned to railroad beneficiaries who enroll with the Social Security Administration are not identified as applying to railroad beneficiaries (because the beneficiary does not make this known), many railroad beneficiary claims are submitted to other carriers and require rerouting to Travelers Insurance Company. This is expensive and a cause of delay in making payments.

The committee agrees with the provision in the House bill which provides that the Railroad Retirement Board shall be responsible for collection of supplementary medical insurance premiums for all enrollees who are entitled under that program. This change will eliminate the confusion, payment delay, and administrative expense deriving from the related provisions of present law.

This provision would be effective for premiums becoming due and payable after June 30, 1971.

2. PROVISIONS OF THE HOUSE BILL WHICH WERE SUBSTANTIALLY MODIFIED BY THE COMMITTEE

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

(Sec. 221 of the bill)

Under title XVIII depreciation on buildings and equipment, and interest on loans used to acquire them, are reimbursable as part of the cost of providing services to medicare beneficiaries. Such reimbursement is paid without regard to whether the items were constructed or purchased in conformity with any type of health facility planning requirement. Similarly, reimbursement on a cost basis for inpatient hospital services provided under titles V (maternal and child health) and XIX (medicaid) of the Social Security Act includes a recognition of certain capital costs without regard to conformance to planning requirements.

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive areawide planning for the development and utilization of all types of health care facilities. But the acceptance of the purposes of State and areawide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end result

of such planning. Thus, while a significant amount of Federal money is currently being expended under the comprehensive health planning provisions of the Public Health Service Act in the interest of furthering health facility planning at the State and local levels, Federal funds are being expended for health services provided under medicare, medicaid, and the maternal and child health programs without regard to whether the facilities providing the services are cooperating in such health facility planning. The committee believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, the committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts, in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State, and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health care planning agencies. On the areawide level, 127 planning agencies are receiving Federal grants: 36 of such agencies are operational. It is estimated that 140 areawide planning agencies will be receiving grants by the end of fiscal 1971 and that more than 70 of such agencies will be operational.

To avoid the use of Federal funds to support unjustified capital expenditures and to support health facility and health services planning activities in the various States, the Committee on Finance approves, with changes concerning the inclusion of health maintenance organizations and appeals procedures, the House provision which would authorize the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement amounts to providers of services under title XVIII and health maintenance organizations for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to certain capital expenditures that are determined to be inconsistent with State or local health facility plans. (Similar authority would be provided with respect to the Federal share of payment for inpatient hospital care under titles V and XIX.) Capital expenditures for the purposes of this provision include expenditures (1) for plant and equipment in excess of \$100,000; (2) which change the bed capacity of the institution; or (3) which substantially change the services provided by the institution. The Secretary would take such action on the basis of findings and recommendations submitted to him by various qualified planning agencies. If he determines, however, after consultation with an appropriate national advisory council, that a disallowance of capital expenses would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he would be authorized to allow such expenses.

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit their findings and recommendations (along with those of other qualified planning agencies) with respect to proposed capital expenditures that are inconsistent with the plans developed by such agencies. (All such health facility and health services planning agencies must have governing bodies or advisory bodies at least half of whose members represent consumer interests.) The committee has modified the House provision so that an adverse decision by a State planning agency may be appealed to an appropriate agency or individual at the State level. The Secretary would be authorized to pay from the Federal Hospital Insurance Trust Fund the reasonable costs incurred by the planning agencies in preparing and forwarding findings and recommendations. The bill would in no way change the autonomy or authority of existing State or local planning agencies, or the relationship between such agencies, either within States or across State lines.

It is not intended that any new planning agencies be established where existing State and local agencies are available and capable of assuming necessary responsibility. The statewide agency may make use of local agencies to assist it. Existing local planning agencies should be utilized, however, only to the extent that they are broadly representative of health care interests in the community. The Secretary should assure himself that a local planning agency selected to make such recommendations to the statewide agency is broadly representative of the interests of various types of health care and services and that no single type of facility or service would control the planning and approval mechanism. Additionally, such local agencies should employ or regularly utilize the services of personnel knowledgeable in health care planning. It is expected that decisions to approve capital expenditures would be made only after thorough consideration has been given to alternative health care resources already available in the area or approved in a given community or medical service area, including outpatient and other alternative sources of care which may lead to reduced needs for inpatient beds. The statewide agency with overall responsibility should, wherever possible, be the Comprehensive Health Planning Agency.

These limitations would be effective with respect to obligations for capital expenditures incurred after June 30, 1971, or earlier, if requested by the State.

REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

(Sec. 222 of the bill)

Under present law, institutional providers furnishing covered services to medicare beneficiaries are paid on the basis of the reasonable cost of such services. Payment on this basis, with retroactive corrective adjustments, is consistent with the long history of public and private third party agency reimbursement for institutional health care on a cost basis. However, as experience under the medicare,

medicaid, maternal and child health, and other third party programs has clearly demonstrated there is little incentive in cost reimbursement as presently employed to contain costs or to produce the services in the most efficient and effective manner.

The committee believes that payment determined on a prospective basis offers the promise of encouraging institutional policymakers and managers, through positive financial incentives, as well as the risk of possible loss inherent in that method, to plan, innovate and generally to manage effectively in order to achieve greater financial reward for the provider as well as a lower total cost to the programs involved. Prospective reimbursement differs from the present method of reimbursement in that a rate of payment is set in advance of the period over which the rate is to apply. The theory is that once the rate is set a provider will institute cost saving measures which will maximize the difference between its actual costs and the higher prospective rate. This difference could be expressed as the "profit." Of course, if the provider's costs turned out to be higher than the prospective rate, there would be a loss. Theoretically, this approach to reimbursement introduces incentives not present under the existing reimbursement method which, since it tends to pay whatever the costs turn out to be, provides no incentives for efficiency.

However, the committee is well aware that in considering such a fundamental change in the present reimbursement method, possible disadvantages as well as the potential advantages must be taken into account. While it is clear, for example, that prospective rate setting will provide incentives for health care institutions to keep costs at a level no higher than the rates set, it is not clear that the rates set would result in government reimbursement at levels lower than, or even as low as, that which would result under the present retroactive cost finding approach. Providers could be expected to press for a rate that would cover all the costs, including research costs and bad debts, as well as margins of safety in the prospective rates that might result in reimbursement—if their requests were met—in excess of the costs that would have been reimbursed under the present approach. Moreover, any excess of reimbursement over costs to voluntary providers would probably be used to expand services, and the new level of expenditures might be reflected in setting higher prospective rates for future years.

Also to be considered is the fact that under prospective reimbursement it will be necessary to take steps to assure that providers do not cut back on services necessary to quality care in order to keep actual costs down and thus increase the difference between costs and the prospective rate established. The development of adequate and widely-agreed-upon measures of quality of care will clearly be needed to provide that assurance and should be immediately developed by the Department.

In view of the far-ranging implications of such a change in the approach to reimbursement, the Committee on Finance agrees with the House bill which provides for a period of experimentation under titles XVIII, XIX and V with various alternative methods and techniques of prospective reimbursement. It is the intent of the committee that experimentation be conducted with a view to developing and evaluating methods and techniques that will stimulate providers through positive financial incentives to use their facilities and personnel

more efficiently, thereby reducing their own as well as program costs while maintaining or enhancing the quality of the health care provided.

The experiments and demonstration projects directed to be carried out under this provision are to be of sufficient scope and on a wide enough scale to give assurance that the results would obtain generally (but not so large or comprehensive as to commit the programs to any prospective payment system either locally or nationally). No experiment or demonstration project is to be undertaken by the Secretary until he consults with and takes into consideration the advice and recommendations of recognized specialists in the health care field who are qualified and competent to evaluate the feasibility of any given experiment or demonstration project.

Under the committee's bill, the Secretary would be required to submit to the Congress no later than January 1, 1973, a full report of the results of the experiments and demonstration projects, as well as an evaluation of the experience of other programs with respect to prospective reimbursement. The report is to include detailed recommendations with respect to the specific methods that might be used in the full implementation of a prospective reimbursement system.

Although recognizing the promise and potential offered by prospective reimbursement the committee does not wish to preclude experimentation with other forms of reimbursement. The committee believes that a solid foundation of experience is required with all possible alternative forms of reimbursement before permanent changes can be made. The bill therefore includes authorization for the Secretary of Health, Education, and Welfare to engage in experiments and demonstration projects involving negotiated rates, the use of rates established by a State for administration of one or more of its laws for payment or reimbursement to health facilities located in such State, and alternative methods of reimbursement with respect to the services of residents, interns, and supervisory physicians in teaching settings. Authority is also provided to make payments, on an experimental or demonstration project basis, to organizations and institutions for services which are not currently covered under titles V, XVIII, XIX, and which are incidental to services covered under the programs, if the inclusion of the additional services would offer the promise of program savings without any loss in the quality of care.

The committee has modified the House provision so as to make clear that this authority with respect to experiments and demonstrations also encompass community mental health centers and, as discussed below, certain ambulatory health care facilities.

It is intended that benefit costs and administrative costs incurred under this section would be paid out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in reasonable proportion to the participation of medicare in the project. Medicaid and private funds would also be used proportionately when medicaid and private programs participate in the project.

The Secretary is to submit to the Committee on Ways and Means and the Committee on Finance plans for each experiment or project, authorized under these provisions, a description, in detail, of its nature, methodology, and objectives. The intent is that there be an opportunity for congressional study before the experiment or project is put into operation.

Recently, a new type of health care facility—the ambulatory surgical center—has come into existence. This type of facility is operated independently of a hospital and is primarily engaged in performing on an outpatient basis surgical procedures which usually involve the use of general anesthesia.

Under the medicare law, reimbursement for services provided in ambulatory surgical centers is limited to the reasonable charges for physicians' services. No reimbursement is made for costs attached to the facility itself—that is, cost of the operating room, the recovery room, or other space provided. The committee believes that such facilities may meet a useful need, in economical fashion, in the health care delivery system. However, the committee believes that it is advisable to defer consideration of this type of facility as provider of services under medicare until the concept of an ambulatory surgical center can be further evaluated. At present there is a lack of agreement among professional people as to the feasibility and desirability of these centers.

The committee added to the House bill a provision which would authorize the Secretary to conduct a study of the various types of facilities engaged in providing surgical or other services to ambulatory patients. If, as a result of this study, the Secretary finds that coverage of presently noncovered services provided by one or more types of ambulatory surgical or health care centers offer promise of improved care or more efficient delivery of care and would not result in cost to the program in excess of what would otherwise be incurred for such services, he would be authorized to enter into an arrangement with one or more of such facilities to conduct a demonstration project to determine the best method of reimbursing such facilities under medicare.

These provisions will be effective upon enactment of the bill.

LIMITATIONS ON COVERAGE OF COSTS UNDER THE MEDICARE PROGRAM

(Sec. 223 of the bill)

The committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. The committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. The committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from gross inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those

elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

In commenting on the wide variations in per diem direct expenses for hospitals in New York City, J. Douglas Colman, president of the Associated Hospital Service of New York, noted in a paper prepared in connection with the National Conference on Medical Costs held on June 27-28, 1967; that:

Some of the variations can be explained by varying characteristics of the patient census, by location, by scope of services offered, or by variations in the efficiency of physical plant. But none of these, nor any combination of them, satisfactorily account for the range of variation shown. For example, the range for voluntary teaching hospitals in New York City alone is from 38 percent above to 20 percent below the median per diem cost for this group of hospitals. One must conclude that at least a part of this variation reflects variations in efficiency.

The data being cited by Mr. Colman indicated that direct costs of "hotel" services (food and room costs) in hospitals in New York City varied from \$17 to \$32 per patient day with a median of \$23, but three hospitals were at the level of \$30 or more, more than 25 percent above the median. Nursing service costs varied from \$11 to \$20 per patient day with a median of \$12 and the hospital with the highest nursing costs had nursing costs almost \$3 per day above the hospital with the next highest nursing costs.

Where the high costs do in fact flow from the provision of services in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not the committee's view that if patients desire unusually expensive service they should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly, when the high costs flow from gross inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. (The committee modified the House provision so as to apply a test of "gross" inefficiency rather than inefficiency.) Health care institutions, like other entities in our economy, should be encouraged to perform efficiently, and when they fail to do so should expect to suffer the financial consequences. Unfortunately, a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in

line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

The committee approves the House provision which would give the Secretary new authority to set limits on costs recognized for certain classes of providers in various service areas. This new authority differs from existing authority in several ways and meets the particular problems identified above. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary for the costs of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made.

The committee is aware of the magnitude of the task this proposal will impose on the Social Security Administration and on the other components of the Department of Health, Education, and Welfare that will be involved in implementing the authority it grants. Difficulties may be encountered as a result of deficiencies in the adequacy and timeliness of cost data and as a result of limitations in current methodology for comparing costs of health care institutions, measuring health care output and estimating the costs necessary to the efficient delivery of health care. On the other hand, the committee does not believe that the Congress should delay in enacting provisions controlling escalation of hospital and other health care costs until perfect methods of collecting and evaluating cost data are attained. What is intended by the committee's proposal is that limits on recognition of costs as reasonable under medicare, medicaid, and the child health programs be put into effect to the extent presently feasible and that these limits be refined and extended over time as developing cost data and methodology permits.

The committee recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently deliver-

ing needed health care. Further, the committee recognizes that these provisions will apply to a relatively small number of institutions. The data that is available for this purpose will often be less than perfectly reliable—for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year. Also, the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care—for example, the costs of the "hotel" services (food and room costs) provided by hospitals—the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical record costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits. In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity—particularly relatively high personnel costs in relation to patient loads where occupancy rates are low—in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of the classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

Providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community.

The determination of the cost of the excess items or services for which the beneficiary may be charged will be determined on the basis of costs previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from \$4 to \$9 a day with a median cost of \$5 a day and

the limit for food services set by the Secretary for 1971 was \$7.20 a day, the hospital previously experiencing costs of \$9 a day could charge patients \$1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

These provisions would be effective with respect to accounting periods beginning after June 30, 1971.

LIMITATIONS ON FEDERAL MEDICAID MATCHING

(Sec. 225 of the bill)

The committee is concerned over the fact that there exists in many areas of the country a substantial degree of overutilization of institutional care. This has been repeatedly demonstrated by investigations of the General Accounting Office and in HEW Audit Agency reports. Additionally, many States have not properly complied with utilization review and independent medical audit requirements.

While Federal dollars should be used to match State medicaid dollars for the coverage of necessary institutional services under title XIX, those Federal dollars should not be used to pay for unnecessary or inappropriate institutional services.

The House of Representatives shared this concern. In order to discourage and prevent overutilization, the House bill provided for a one-third cutback in Federal matching for patient stays which exceed (a) 60 days in a general or TB hospital; (b) 90 days in a skilled nursing home; and (c) 90 days in a mental hospital. In addition, there would be no Federal matching after an additional 275 days of care in a mental hospital during an individual's lifetime.

Despite general agreement with the objectives of the House bill the committee believes that the approach of the House bill is inadequate because it fails to differentiate between those States which are adequately controlling utilization and those which are not; thereby unjustifiably penalizing some States.

Therefore, the committee substituted for the House provision an amendment which would authorize the Secretary to reduce the Federal matching percentage on a selective basis with respect to those States where he finds overutilization, inadequate independent medical and professional audits, inadequate utilization review procedures or other inappropriate use of facilities (including intermediate care) or services. To facilitate arrangements for necessary independent professional and medical audits, the committee in another amendment authorizes 75 percent Federal matching toward the costs of professional personnel involved, including those under contract. Present law limits the 75 percent matching to professional personnel costs of employees of the State

agency only. The committee bill would provide that percentage reductions would be made with respect to improperly or inadequately monitored care or services and would be graded on a basis reasonably related to the estimated extent of the increased program costs resulting as a consequence of inadequate or improper controls on services. In making these determinations, the Secretary would utilize audit reports, estimates, statistical samples and other information available to him.

The committee believes that this approach would differentiate between those States which are adequately controlling utilization and those which are failing to meet this objective, and would not unfairly penalize those States which have effectively established such controls.

The amendment would be effective upon enactment.

PAYMENT FOR SUPERVISORY PHYSICIANS IN TEACHING HOSPITALS

(Sec. 226 of the bill)

A major problem in the administration of the medicare program has arisen concerning the payment, under part B, on a fee-for-service basis for the services of "supervisory" physicians in teaching hospitals. These payments are estimated to involve more than \$100 million annually. In general, such payments were not customary prior to medicare and it was not intended that medicare cover noncustomary charges.

The Comptroller-General of the United States shares the concern of the committee. He has submitted several reports to the committee relating to medicare payments for teaching physicians which document and detail the dimension of the problem confronting medicare in this area.

Teaching hospitals have a large number of "institutional" patients. The services to institutional patients are often actually provided by interns and residents. The salaries of these interns and residents are recognized in full under part A of medicare as a hospital cost. Medicare regulations (not the statute) offered teaching institutions and teaching physicians an opportunity to obtain funds through billing the institutional patient as if he were a private patient. Medicare may, when it also pays for the "supervisory" physician under part B, end up actually paying for the same service twice—first when it pays the salaries of the interns and residents who provide care and second, when the teaching physician submits his bill. This demand on part B funds results essentially in millions of aged people subsidizing medical education through their part B premiums.

H.R. 17550 as passed by the House has a section on payment for physicians' services in the teaching setting which attempts to deal with this problem. The approach in the House bill is to define the conditions under which fee for service will not be payable (basically where nonmedicare patients are not required to pay a charge by a teaching physician). Where a fee for service is not payable, the House bill provides for reimbursement on an actual costs basis under part B.

The difficulty with the approach in the House bill is that it might tend to encourage teaching hospitals and teaching physicians to introduce or expand the practice of billing by teaching physicians of nonmedicare patients on a fee-for-service basis.

The Association for Hospital Medical Education (AHME) testified in hearings before the committee that the services rendered to "institutional patients" have usually been rendered by residents and interns in training under the general supervision of full- or part-time "supervisory" physicians. The AHME further noted that there have been instances where the care rendered by interns and residents to institutional patients who are medicare beneficiaries has been reimbursed under part A, and reimbursement for the same service has been sought by the "supervisory physician under part B." The committee agrees with their statement that this double reimbursement is unequivocally wrong.

The recommendation concerning appropriate payment for teaching services made by the Association for Hospital Medical Education seems to provide a sounder basis for reasonable solution of this costly problem than that provided under the House bill.

Accordingly the committee has approved and the Department of HEW endorses an amendment providing that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary for all full-time physicians (other than house staff) at the hospital or, where such salaries do not provide a proper basis, at like institutions in the area. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervisory voluntary service on a regularly scheduled basis to nonprivate patients. Such services would be billed for by the organized medical staff of the hospital and reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time which would otherwise have to be obtained through employed staff on a reimbursable basis. Such funds would in general be made available on an appropriate legal basis to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

There are also teaching physicians whose compensation is paid by a medical school. With respect to reimbursement for their direct or supervisory services for nonprivate medicare patients, payments

should be made on the basis of actual or salary-equivalent costs. The funds so received may be assigned by such physicians to an appropriate fund designated by the medical school for use in compensating teacher physicians, or for educational purposes. Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' service were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

The committee recognizes, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services. Furthermore, in some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on a cost basis, as it could have been paid under the original medicare law, if the election would be advantageous to the program in that it might reduce billing difficulties and costs.

The committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

Unlike the House bill, the committee amendment calls for the cost-reimbursement payments for inpatient services to be made under part A of the program wherever the patient is eligible under part A. To assure equitable payment and no loss to the hospital on services to medicare patients where the cost reimbursement approach is applicable, cost-reimbursement payments would be made under part B where a part B enrollee is not insured under part A or where an insured inpatient has exhausted his part A hospitalization coverage.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills. While the House bill would also simplify administration, it would still be necessary under that bill to make such a distinction for purposes of determining the respective liabilities of the part A and part B trust funds.

The committee also provides that the law be amended so that a hospital could include the actual reasonable costs which an affiliated medical school incurs in paying physicians to provide patient care services to medicare patients in the hospital. The bill would also permit including in a hospital's reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. The hospital would be required to pay the reasonable cost of the services in question to the institution that bore the cost.

The above provisions would become effective with respect to accounting periods beginning on or after July 1, 1971.

INSTITUTIONAL PLANNING UNDER MEDICARE PROGRAM

(Sec. 231 of the bill)

Under present medicare law, there is no requirement for providers of services to develop fiscal plans such as operating and capital budgets. However, the committee is aware of the fact that health care facilities have come under increasing criticism on the grounds that they fail to follow sound business practices in their operations. The Advisory Committee on Hospital Effectiveness, established by the Secretary of HEW in its report stated, "* * * the fact must be faced that deficiencies in hospital management owe something, at least to inattention, indifference, or lack of information on the part of some hospital boards, and some trustees with the best intentions and energy have not been adequately informed by administrations on what the functions of a hospital trustee, or a hospital should be." In recommending

the requirement contained in the bill, the Secretary's committee stated, "The requirement that detailed budgets and operating plans be prepared annually as a condition of approval for participation in Federal programs can be expected to disclose management inefficiencies in such health care institutions as a necessary first step toward bringing about needed improvements. Especially, the committee believes this requirement will compel the attention of many hospital trustees to lapses in management that would not be permitted in their own businesses."

The Committee on Finance agrees with the provision in the House bill which would require, providers of services (including hospitals accredited by the Joint Commission on Accreditation of Hospitals) as a condition of participation under the medicare program, to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan.

However, the committee has modified the House provision so that the required annual operating budgets may be prepared by groupings of cost or income rather than a detailed itemization for each type of cost or income. The overall plan would be expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of \$100,000 for acquisition of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and the proposed methods of financing such costs. It would have to be prepared under the direction of the governing body of the institution, by a committee consisting of representatives of that body, the administrative staff and the medical staff. The plan would cover the immediately following year and the immediately following 3-year accounting period and would be reviewed and updated annually to assure that it is consistent with the budgetary program of the provider.

The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process.

The new condition of participation would have to be met with respect to any provider of services for fiscal years of the provider beginning after June 30, 1971.

ADVANCE APPROVAL OF EXTENDED CARE AND HOME HEALTH COVERAGE UNDER MEDICARE

(Sec. 233 of the bill)

Under present law, extended care benefits are payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The home health benefit is payable on behalf of patients who need essentially the same type of nursing care on an intermittent basis. Skilled nursing care has generally been defined as the provision of identifiable skilled nursing procedures, although some authorities have argued that this definition does not adequately take into account the supervisory role

of a skilled nurse under whose presence and supervision a relatively unskilled person can participate in providing a skilled service. The usual administrative process for determining eligibility for payment involves retrospective review of the services actually furnished to the patient.

The committee believes that in practice, the administration of extended care and home health benefits has proved difficult and has led to considerable dissatisfaction. The complexity of the extended-care coverage determination, and the fact that it must often be made retroactively, tends to create confusion regarding the type of care which is reimbursable and may encourage physicians to either delay discharge from the hospital, where coverage is less likely to be questioned, or to recommend a less economical, though financially more predictable, course of treatment. The aggregate effect is to reduce the value of the extended care benefit as a continuation of hospital care in less intensive—and less expensive—setting as soon as it is medically feasible for the patient to be discharged from the hospital. Patients receiving care at home or who might be ready for discharge if sufficient assistance were available at home face a somewhat similar situation with respect to home health benefits. The uncertainty of coverage of services may impede effective discharge planning or the formulation of a comprehensive health care plan for a homebound patient.

The House sought to alleviate the problem by including a provision authorizing the Secretary to establish presumptive periods of coverage according to diagnosis and other medical factors for patients admitted to an extended care facility or started on a home health plan. While this approach seeks to alleviate much of the administrative complexity by focusing determinations on the totality of needs of certain categories of patients, rather than evaluation of specific nursing procedures, it introduces certain new administrative problems. The wide range of illnesses common to the aged, as well as the frequent occurrence of "combination diagnoses" makes specific categorization difficult.

The committee's bill, therefore, includes a provision designed to (1) respond more effectively to the needs of beneficiaries, including those for whom a short period of institutional care under continuing skilled supervision is needed to restore self-sufficiency and (2) substantially eliminate retroactive determinations. Under the committee's bill, emphasis in determining coverage would be placed on advance evaluation of the patient's need for a type of institutional care which requires the continuing availability of skilled nursing and related skilled services, in contrast to present law which requires continuing need for skilled nursing and other related skilled services. In all cases, the attending physician would be expected to certify the need for such care and provide a plan of treatment to the extended care facility or home health agency in advance of admission or start of care.

In lieu of predetermined periods of extended care coverage based on diagnoses, the committee's bill encourages and anticipates, that to the maximum extent feasible, preadmission evaluation and approval on an individual-case basis of the need for extended care. Such reviews could be performed by the Professional Standards Review Organization, hospital utilization review committee, or other appropriate group. Unless disapproved in advance, coverage upon admission would con-

tinue for the lesser of either the initially certified and approved period, until notice of disapproval, or 10 days. The physician and facility would be expected to forward supporting documentation for continued coverage of patients usually at least 3 days prior to expiration of the initially approved period or upon request of the review group. Where certifications and evidence are provided on a timely basis, any subsequent determination (for purposes only of determining medicare payment liability) that the patient no longer requires covered care would be effective beginning the third day after notification to the facility, thus giving the patient and his physician an opportunity to make other arrangements to meet the patient's needs.

Administration of the home health benefit would follow essentially the same approach. Review of the proposed plan of treatment, prior to its implementation, would be made wherever possible and could be performed by a PSRO, the utilization review committee of the institution from which the patient is being discharged (for part A home health benefits) or other qualified group. In the absence of a negative finding or a specific limitation, payment would ordinarily be made for up to 10 visits before additional review of the patient's needs was required. (The 10-visit limitation would apply on a calendar-year basis for part B home health benefits.) Where evidence and certifications were submitted promptly, determinations that the patient no longer needs the type of home care covered by medicare would be made prospectively.

As indicated, coverage of up to 10 home health visits would be presumed for both part A and part B. Where the patient has 10 days of coverage presumed for purposes of part A, he may *not* immediately thereafter have a new presumed period begin under part B. However, when a patient first has presumed coverage under part B and then needs to go to the hospital, presumed part A visits following institutionalization *would be* permissible (adding up to as many as 20 visits). The fact that the patient required hospitalization is an indicator of a change in his condition that would not be present where the patient merely switches from part A to part B coverage while remaining at home.

This provision would be effective with respect to admissions to extended care facilities, and home health plans initiated, after June 30, 1971.

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

(Sec. 239 of the bill)

Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single prospective capitation payment such as the organizations normally charge for services covered under both the hospital insurance and supplementary medical insurance parts of the medicare program. Instead, medicare reimbursement to group practice prepayment plans, whether it is made on a cost or charge basis, must be related, retrospectively, to the costs to the organization of providing specific services to beneficiaries, so that some of the financial incentives which such organizations may have in their regular non-medicare business to keep costs low and to control utilization of serv-

ices are not fully incorporated directly in their relationship with medicare.

Of course, the committee believes that a proper sense of professional responsibility also should obtain in patient care and should be of greater significance than economic incentives in assuring appropriate utilization of health care services.

Nonetheless, a disincentive to control of costs and utilization of services which occurs to an extent in the present, usual approach to payment for services in the health field, either by private patients, private insurance, or the Government, is that, in effect, payment is made to the provider for each individual service performed, so that other things being equal, there is an economic incentive on the part of those who make the decisions on which services are needed to provide more services—services which may not be essential, and even unnecessary services. Another area of concern is that, ordinarily, an individual must largely find his own way among various types and levels of services with only partial help from a single hospital, a nursing home, a home health agency, various specialists, and so on in terms of referral to appropriate sources of care. The pattern of operation of certain organizations (such as the Kaiser Health Care Foundation and H.I.P.) which provide services on a per capita prepayment basis may lend itself to possible solution of both of these problems with respect to the care of individuals enrolled with them. Because the organization receives a fixed annual payment from enrollees, regardless of the volume of services rendered, there is a financial incentive to the organization, by its administrative supervision and review, to control costs and to provide only the least expensive service appropriate to the enrollee's needs. The incentive to the organization may be passed on to the doctor by paying him on a salary basis and providing a bonus or similar profit-sharing arrangements when costs are kept low. Moreover, such existing organizations assume responsibility for deciding on the services which the patient should receive. On the other hand, there is also present in such systems an economic incentive to provide less care than is necessary so as to reduce costs and further maximize financial gain.

The committee believes it is desirable for medicare to relate itself to prepayment health care organizations in a way which conforms more nearly to their usual way of doing business. The objective is to reinforce, in the case of medicare beneficiaries, the financial incentives—if professional incentives are insufficient—which health maintenance organizations have with respect to their other enrollees.

The health maintenance organization provision of the bill, strongly endorsed and advocated by the Department, is intended to contribute to reductions in the cost of health care delivery and to improve quality of care under the medicare program. The committee is concerned that, to the contrary, the health maintenance organization provision could turn out to be an additional area of potential abuse which might have the effect of increasing health care costs—paying a larger profit than is now or should be, paid to these organizations—and decreasing the quality of service available or rendered.

However, if the safeguards the committee has added are properly administered, it may be that the stated goals of the provision can be achieved. In any event, this new program is unquestionably an area

where the Office of the Inspector General (which would be established under a committee amendment to the bill) can make a major contribution toward assuring that health maintenance organizations are operated consistent with principles of efficiency and economy and, particularly, that they comply strictly with the statute and the legislative intent of the Congress.

Accordingly, while it has reservations about the proposal, the committee has adopted, with certain tightening changes, the amendment in the House bill under which medicare payment to a so-called Health Maintenance Organization (HMO) with respect to beneficiaries enrolled with it could be made on a prospective per capita basis, encompassing services covered under both hospital insurance and supplementary medical insurance. (Group practice prepayment plans could, of course, choose to continue to be reimbursed under the provisions of existing law if they wished.) The additions and modifications made by the committee reflect its desire to assure that health maintenance organizations are afforded opportunity to demonstrate their capacity to provide comprehensive care economically and efficiently without endangering either the health interests of program beneficiaries or the integrity of the trust funds.

Under the House bill, a prospective rate of payment would be determined annually in accordance with regulations of the Secretary, taking into account the organization's premiums with respect to non-medicare enrollees (with appropriate actuarial adjustments to reflect the difference in utilization patterns and other relevant factors between those under 65 and those over 65). This payment would be no more than 95 percent of the estimated amount (with appropriate adjustments—such as age and morbidity differentials—to assure actuarial equivalence) that would be payable if such covered medicare services were furnished outside of the framework of a health maintenance organization.

The committee bill would modify in several ways the House bill's provisions for determining payment to HMO's. First, rather than limiting payment to the lesser of (a) an adjusted premium amount or (b) 95 percent of the estimated amount that would be payable if the covered services were to be furnished by other than health maintenance organizations, the committee bill would authorize payment at the 95 percent of the actuarial equivalent rate but only if the health maintenance organization provides the Secretary with satisfactory assurances that any excess over the adjusted premium payment will be returned to beneficiaries in the form of expanded benefits or reduction in amounts charged as the equivalent of medicare's deductibles and coinsurance. HMO's will thus have funds, where performance is efficient and necessary care has been properly provided, to improve benefit protection or reduce premium costs for medicare enrollees and thereby possibly attract further enrollment. Under this modification beneficiaries, who upon enrollment with an HMO forgo coverage of most nonemergency out-of-plan services, would have some incentives for enrollment.

Second, with respect to the health maintenance organization's premiums which would be taken into account in medicare's payment determination, the committee bill adds a provision intended to alleviate a

concern that the proposed payment determination might reward profiteering by relating payment to premiums that contain an unjustifiably high retention (margin over direct benefit and administrative costs.) The Committee limits the retention to the lesser of: (i) the retention rate (excluding the administrative expenses) as a percentage of the net premium for people under age 65, or (ii) 150 percent of the dollar amount of retention (excluding administrative expenses) per capita for enrollees who are under age 65 of the HMO.

Third, the 95 percent payment rate, which would be authorized where the Secretary has received the necessary assurances from the health maintenance organization, would be based on estimated benefit costs only plus an estimated allowance for administrative expenses reasonably related to the actual expenses of such a HMO and the expenses of comparable organizations. This approach recognizes that a health maintenance organization's administrative expenses can be expected to be lower than those of carriers and intermediaries because HMO's need not perform all of the functions of carriers and intermediaries. For example, HMO's generally do not pay small individual physician fee-for-service claims.

Fourth, there would be an overall ceiling on payment to a health maintenance organization equal to 95 percent of the estimated amount for benefit cost and administrative expenses, including only carrier and intermediary administrative costs (exclusive of auditing expenses), payable if covered services were to be furnished by other than health maintenance organizations. This ceiling, and the 95 percent payment rate mentioned in the preceding paragraph, would be based upon the reimbursement amount per capita for the Nation adjusted for variations in unit benefit cost due to service areas, reasonable availability of services, and underwriting rules. The service area concept encompasses the geographical locality where the health maintenance organization is providing the service, and in which there is a reasonable cross section of different types of institutions and practitioners and utilization rates. Where there is an abnormal scarcity of services or excessive services for persons not in the HMO in a particular locality, but the needs of HMO members are fully met, the actuarial equivalent cost would be determined by established actuarial methods which include the consideration of costs in comparable locations where the covered services are reasonably available. In negotiating and reviewing rates of payment, the committee expects that such negotiations will be conducted, on the part of the government, on an arms-length basis by qualified and expert personnel. The actuarial determinations should be performed by qualified actuaries experienced in health care program costing. This expertise also would be needed to appraise whether enrollment of poorer risks, such as institutionalized persons or persons of low income, was less than in proportion to the population in the service area and to determine the effects on costs. Similarly special limitations of the HMO on access of members to care, on limitations on the provision of teaching and community services should also be taken into account in considering cost equivalence.

Fifth, the committee has included an additional safeguard which would authorize the Secretary to adjust, retroactively, any payments

made to a health maintenance organization on the basis of projected national average costs, if it is later determined that such projections were based on erroneous data or if actual experience differs substantially from the assumptions upon which the projections were made. Such adjustments, which could result in either increase or decrease in program payments, must be determined within 3 years following the close of the accounting period to which the adjustment applies.

Under this basis for payment, the health maintenance organization should be encouraged to manage its resources and provide a level of service within a predictable premium income; extensions and improvements in service could thus also be provided to beneficiaries from utilization and other savings which the organization may be able to make over more traditional methods of providing services.

For ease of calculation of amounts to be paid from the two trust funds, payments to health maintenance organizations would be made from both the hospital insurance and supplementary medical insurance trust funds with the portion from the supplementary medical insurance trust fund being the product of the total monthly premium (beneficiary and Federal Government amounts combined) times the number of medicare beneficiaries enrolled in the organization rather than an actuarially determined part B cost within the HMO. The remainder of the HMO payment would be made from the hospital insurance trust fund.

Under the House bill, the individuals with respect to whom such payment would be made are medicare beneficiaries entitled to both hospital insurance and supplementary medical insurance who are enrolled with a health maintenance organization. Since some potential health maintenance organizations have substantial numbers of members who, because of noncoverage under social security in the past, are not eligible for hospital insurance benefits (or who would be eligible for such benefits only by paying their full cost as provided under another proposed amendment), the committee has added a provision which would allow payments to be made for medical insurance benefits alone for enrolled beneficiaries who are not entitled to hospital insurance benefits. Eligible enrolled beneficiaries would, with two exceptions, receive medicare-covered services only through the health maintenance organization. One exception, contained in the House bill, would cover those emergency services as are furnished by other physicians and providers of services; the health maintenance organization would be responsible for paying the costs of such emergency services. The committee would also require a health maintenance organization to pay the cost of otherwise covered and necessary maintenance therapy which an enrollee receives outside the organization because of nonaccessibility or availability of the service directly from the organization. If an enrolled individual received other types of nonemergency care through some means other than the health maintenance organization, he would have to meet the entire expense of such care. The fact that members received some care outside the HMO would be taken into account in calculating the actuarial equivalent cost of the services furnished by the HMO.

To qualify to receive payment in this way, a health maintenance organization would have to be one which provides: (1) either directly or through satisfactory arrangements with others, health services

on a prospective per capita prepayment basis; (2) all the services and benefits of both the hospital and medical insurance parts of the program; (3) physicians' services, either directly by physicians who are employees or partners of the organization, or under an arrangement with an organized group of physicians under which the group is reimbursed for its services on the basis of an aggregate fixed sum or on a per capita basis. Since physicians play the major role in determining utilization of all covered services, such payment arrangement should contain an element of incentive for such physicians to assure that medicare patients are provided needed services in the most efficient and economical manner. (The group of physicians which has the arrangement with the health maintenance organization could, in turn, pay its physician members on any other basis, including fee-for-service.)

The organization would have to have an open enrollment period at least annually under which it accepts enrollees (including undertaking during open enrollment periods specific and active efforts to contact, inform, and enroll institutionalized beneficiaries) on a nondiscriminatory basis up to the limits of its capacity. An organization which does not accept applications for enrollment from a significant and representative proportion of eligible applicants during two consecutive open enrollment periods may be terminated if adequate justification is not provided.

Additional requirements are: (1) that the organization furnish to the Secretary proof of its financial responsibility and its capacity to provide comprehensive health services, including institutional services, effectively and economically; (2) that there are a minimum of 10,000 enrollees (both medicare and nonmedicare) initially, or, that the HMO can reasonably be expected to attain such minimum enrollment within a period not exceeding 3 years with progressive continuing increases in enrollment toward the minimum during that period; (3) that the organization must have satisfactory procedures assuring that the health services required by its enrollees are received promptly and appropriately and that they are of proper quality.

The various elements of a health maintenance organization, such as hospital, extended care facility, or clinical laboratory, would each continue to have to meet the conditions of participation or other quality standards which apply to such organizations under present law. The committee has added to the House bill a provision which makes it clear that institutions owned or utilized by a health maintenance organization must adhere to the health facility planning requirements which would be applied to other providers of services under provisions of another amendment. Where applicable, appropriate reductions will be made in payments to any health maintenance organization which renders services to beneficiaries through a hospital or other institutions with respect to which the Secretary determines that payment for capital expenditures must be excluded.

With respect to all of the above minimum requirements, it is expected that they will be carefully and fully applied so as to avoid establishment of pro forma HMO's by organizations essentially interested in securing greater levels of reimbursement than are otherwise payable under the regular medicare program and without reducing program costs through increases in effectiveness and efficiency.

Under the House bill, an organization would not qualify under this provision unless at least half of its membership is under age 65. The committee agrees that the membership distribution requirement is a desirable objective in order to assure that the health maintenance organization operates in true competition with other health care delivery mechanisms, but rigid imposition might be detrimental to newly developing organizations and organizations located in retirement areas or deliberately established as part of an effort to bring adequate health care to inner-city or rural areas. Therefore, the committee has modified the House requirement to permit the Secretary to initially waive the one-half enrollment requirement for up to 5 years if compliance would otherwise cause substantial reduction in enrollment, provided the organization furnishes evidence of sustained and substantial efforts to achieve the required enrollment distribution or, in rare instances, to waive the requirement completely if it is determined that failure to meet the requirement is due to geographic or other circumstances beyond the organization's control.

If the health maintenance organization provides only the services for which the enrollee is covered by the medicare program, the premiums it may charge its enrollees cannot exceed the actuarial value of the cost-sharing provisions of the hospital and supplementary medical insurance parts of the medicare program, whichever are applicable to the enrollee. If, however, the organization provides its enrollees services in addition to those covered under medicare, it must inform enrollees of the portion of the premium applicable to such additional services, and the portion applicable to medicare-covered services may not exceed the actuarial value of the cost-sharing provisions of the medicare program. The reasonableness of premiums charged for additional services will be determined by the Secretary in accordance with regulations. These requirements are intended to assure that beneficiaries enrolled with health maintenance organizations benefit fully from their medicare coverage and are, in fact, charged no more than the deductible and coinsurance amounts. This provision will also help to assure that they are made aware of the exact cost of any benefits provided by the health maintenance organizations which are in addition to medicare coverage and that such cost is reasonable in relation to the additional benefits provided.

Beneficiaries enrolled with a health maintenance organization who are dissatisfied with decisions of the organization as to benefit coverage would have the right to a hearing before the Secretary, in which the health maintenance organization would be an interested party, and to judicial review with respect to disputes involving amounts exceeding specified limits.

Beneficiaries could terminate their enrollment with a health maintenance organization and revert to regular coverage under the program in accordance with regulations. It is expected that, generally, disenrollment would take effect at the same time after the disenrollment request as is the case now with respect to disenrollment under the supplementary medical insurance program.

Under provisions of the House bill, a health maintenance organization would be treated as a "provider of services," i.e., would be treated in the same manner that hospitals, extended care facilities and certain

other individual agencies and organizations that participate in the program. Such a status connotes a continuing relationship contingent upon compliance with health quality, fiscal, and technical conditions of participation. However, effective administration of the health maintenance organization provision will require an active and comprehensive role by the Secretary in reviewing and evaluating performance of such organizations in relation to the total range of program interests including responsiveness to beneficiary needs as well as adherence to fiscal and quality standards. The committee has therefore amended the House provision to establish a contractual relationship between the Secretary and a health maintenance organization. Such a contract would be renewable annually in the absence of reasonable advance notice by either party of intention to terminate at the end of the current term, except that the Secretary could terminate the contract at any time (after reasonable notice and opportunity for hearing) if he finds that the organization has failed substantially to carry out the contract or is carrying it out in a manner inconsistent with efficient, effective, and economical administration of this section.

Under this provision, it is expected that the Secretary will issue regulations establishing means for effective implementation of an ongoing review program to assure that the health maintenance organization effectively fulfills beneficiary service needs by adhering to specified minimum requirements for full-time qualified medical staff, keeping beneficiaries fully informed on the extent of coverage of services received outside the organization, taking positive actions to assure that beneficiaries are not deprived of benefits through devices such as scheduling appointments at inconvenient times or unwarranted delay in scheduling of elective surgery, and avoiding discrimination against poor health risks through selective enrollment or poor service aimed at encouraging disenrollment of high users of services. The Secretary is also expected to take precautions against possible fiscal abuse of the program by examining (and, where required, taking exception to) any arrangement the health maintenance organization may have with providers, including related organizations, which appear to result in an unwarranted increase in costs or the base premium or to overstate the value of any added coverage or reduction of the deductible.

The committee also notes that some potential qualified health maintenance organizations currently have enrollees who may desire to continue membership in the organization but who do not wish to agree to receive covered services only from that organization. Since it would seem inequitable to require such individuals to either disenroll immediately or involuntarily accept a limitation on their access to covered services, the committee has added a provision under which a health maintenance organization could continue through June 1974 to be reimbursed for covered care provided to beneficiaries who were members prior to July 1971 but who do not elect the option. Program payments in such cases would be determined on a prospective per capita basis similar to that used for enrollees who elect the option, with appropriate payment reductions for projected out-of-plan use of covered services by such enrollees.

The provision would become effective with respect to services provided on or after July 1, 1971.

PHYSICAL AND OTHER THERAPY SERVICES UNDER MEDICARE

(Sec. 254 of the bill)

Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to its outpatients. The physical therapist may be either an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The House bill would provide for coverage, under the supplementary medical insurance program, of up to \$100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or in the patient's home under a physician's plan. Reimbursement for the reasonable charges for the covered services rendered by the physical therapist would be made either to the beneficiary or, on assignment, directly to the physical therapist.

The committee has been advised by the Department of Health, Education, and Welfare that the House bill would be exceedingly difficult to administer in terms of assuring the provision of appropriate services, or of effectively enforcing the health, safety, and quality safeguards embodied in present law, since physical therapists would be furnishing services outside the controlled environment of an institutional setting or responsibility. Moreover, this provision would compound the already costly and troublesome problem of restraining overutilization of physical therapy services. The committee agrees with the Department that at the present time whatever advantage might accrue to beneficiaries from increased availability of services would be at the expense of higher benefit and administrative costs. For these reasons, the committee has deleted this special \$100 feature of the House bill.

The committee is concerned about the few cases under present law where an inpatient exhausts his inpatient benefits or where he is otherwise ineligible for hospital insurance inpatient benefits and can continue to receive supplementary medical insurance reimbursement for physical therapy treatment only if the hospital or extended care facility is able to arrange for another participating facility to furnish the physical therapy treatment as an outpatient service. The House bill would authorize a hospital or extended care facility to furnish outpatient physical therapy services to its inpatients in the above categories. The committee concurs with the House bill on this provision and has provided an effective date, for this subsection, applying to services furnished after June 30, 1971.

The House bill also includes a provision for controlling program expenditures and for preventing abuses. Under the provision in the House bill, the reasonable cost of physical therapy services furnished by a provider of services, or by others under an arrangement with such provider, may not exceed an amount equal to the salary which would have reasonably been paid to a physical therapist if he had

performed the services as an employee. While the committee agrees that effective controls are necessary, it believes that the House provision limiting reimbursement for physical therapy services to a salary-equivalent amount does not take into account expenses a therapist not working as a full-time employee would have. These expenses may include costs of maintaining an office, travel-time and expense, and similar costs. The committee bill, therefore, modifies the House provision to limit reimbursement to a "salary-related" basis which would permit determinations of reasonable cost for physical therapist services to allow for additional expenses which may be incurred by therapists who are not full-time employees of a facility. The Secretary would determine which additional expenses would be allowed. The committee bill would further modify this provision of the House bill to extend this reimbursement limitation to cover other therapy services (such as occupational therapy and speech therapy) furnished by a provider of services or by others under an arrangement with a participating provider, and to services provided by other specialists such as social workers, medical records librarians, dietitians, etc.

The above provision would be effective with effect to accounting periods beginning on or after July 1, 1971.

PAYMENT FOR CERTAIN INPATIENT HOSPITAL AND MEDICAL SERVICES FURNISHED OUTSIDE THE UNITED STATES (Sec. 262 of the bill)

The House-approved bill provides, with respect to admissions after December 31, 1970, for payment of medicare benefits for inpatient hospital services furnished outside the United States if the beneficiary is a resident of the United States and the foreign hospital was closer to, or substantially more accessible from his residence than the nearest hospital in the United States which was suitable and available for his treatment. For such beneficiaries, benefits would be payable without regard to whether an emergency existed or where the illness or accident occurred. Only patient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital-approval program having essentially comparable standards would be covered. (The House-approved bill would retain the provisions of present law with respect to coverage of emergency inpatient hospital services furnished outside the United States.)

Under the bill approved by the House, payment for all covered hospital services furnished outside the United States would be made on essentially the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States. Where the hospital elected to bill the medicare program it would be reimbursed on the basis of the reasonable cost of the covered services furnished the beneficiary, as is now done with respect to emergency services furnished by a nonparticipating hospital which furnishes actual cost data. Where payment could not be made solely because the hospital did not elect to bill the program, benefits would be payable directly to the beneficiary on the basis of an itemized bill if he

filed an acceptable application for reimbursement. Subject to the appropriate deductibles and coinsurance, the beneficiary would be reimbursed in an amount equal to 60 percent of the hospital's reasonable charges for "routine services" in the room occupied by him or in semiprivate accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for "ancillary services," or, if separate charges for routine and ancillary services are not made by the hospital, two-thirds of the hospital's total charges.

The committee is fully in agreement with the objective of the House bill but it is concerned that the hospital services that would be covered under this proposal, along with the coverage provided under present law for emergency hospital services outside the United States, would not adequately protect medicare beneficiaries against other medically necessary health care costs which they may incur while receiving covered foreign inpatient hospital care. Therefore, the committee has amended the House-approved bill to provide for coverage under the medical insurance program of medically necessary physicians' services and ambulance services furnished in conjunction with covered foreign inpatient hospital services.

The committee's bill would limit payment for physicians' services to the period of time during which the individual is eligible to have payment made for the foreign inpatient hospital services he receives. Further, the Secretary would be authorized to establish, by regulations, reasonable limitations upon the amount of a foreign physician's charge that would be accepted as reimbursable under the medical insurance program. In recognition of the administrative difficulties that would arise in applying the assignment method of reimbursement to medical services furnished in other countries, the committee's bill would provide that benefits for foreign physicians' and ambulance services would be payable only in accordance with the itemized bill method of reimbursement provided for under present law.

This provision would apply to services furnished with respect to hospital admissions occurring after June 30, 1971.

3. NEW PROVISIONS ADDED BY THE COMMITTEE

PROVIDE THAT SERVICES OF OPTOMETRISTS IN FURNISHING PROSTHETIC LENSES NOT REQUIRE A PHYSICIAN'S ORDER

(Sec. 203 of the bill)

Under present law, optometric services are not covered except with respect to services incidental to the fitting and supplying of prosthetic lenses ordered by a physician. The House bill does not provide for any change in the present limitation on coverage of optometric services. However, in its report accompanying the bill, the Committee on Ways and Means directed the Department of Health, Education, and Welfare to study the present coverage of optometric services in the interest of removing any existing inequity.

The committee believes that the medicare requirement that a physician's prescription or order accompany requests for payment for covered prosthetic lenses when such lenses are furnished by an optometrist unduly limits both patient and optometrist and should be eliminated. The patient's freedom to choose either an ophthalmologist

or an optometrist to furnish him with prosthetic lenses should no longer be restricted by this requirement.

The committee bill would recognize the ability of an optometrist to determine a beneficiary's need for prosthetic lenses by amending the definition of the term "physician" in title XVIII to include a doctor of optometry authorized to practice optometry by the State in which he furnishes services. An optometrist would be recognized as a "physician" only for the purpose of attesting to the patient's need for prosthetic lenses. (Of course, neither the physician nor the optometrist would be paid by medicare for refractive services when the beneficiary has been given a prescription by a physician for the necessary prosthetic lenses.) This change would not provide for coverage of services performed by optometrists other than those covered under present law, nor would it permit an optometrist to serve as a "physician" on a professional standards review organization.

The amendment would become effective upon enactment.

COVERAGE OF SUPPLIES RELATED TO COLOSTOMIES

(Sec. 204 of the bill)

Medicare covers the bag and straps which must be used in conjunction with some colostomies (an artificial opening of the bowel to the abdominal wall which is often made necessary by surgery for cancer of the bowel). The equipment is covered as it is considered a prosthetic device (a replacement for a body organ).

Some bowel cancer patients have surgery which results in a different type of colostomy necessitating daily irrigation and flushing rather than permanent attachment of a bag. Medicare does not cover this irrigation and flushing equipment, since it is not permanently attached to the body and is therefore not considered a prosthetic device. This results in unequal treatment by the program of patients with colostomies.

The committee bill would add a phrase to the statute to include coverage for material directly related to the care of a colostomy.

The amendment is effective upon enactment.

COVERAGE OF CHIROPRACTIC SERVICES

(Sec. 205 and 280 of the bill)

Under the House bill, the Secretary would be required to conduct a study of chiropractic services covered under State plans approved under title XIX. The study would determine whether and to what extent chiropractic services should be covered under the supplementary medical insurance program of title XVIII, giving particular attention to the limitations which should be placed on such coverage and on the amounts to be paid for whatever services might be furnished. The Committee on Finance believes, however, that further study of chiropractic services under other plans is not required to support coverage of the services of chiropractors under the supplementary medical insurance program.

In providing coverage for the services of chiropractors, the committee recognizes the need for controls on the quality, cost, and utilization of such services. Accordingly, the committee bill would

broaden the definition of the term "physician" in title XVIII to include a licensed chiropractor who also meets uniform minimum standards to be promulgated by the Secretary. The committee believes that at least uniform minimum standards of the following kinds should underlie licensure: satisfactory evidence of preliminary education equal to the requirements for graduation from an accredited high school or other secondary school; a diploma issued by a college of chiropractic approved by the State's chiropractic examiners and where the practitioner has satisfied the requirements for graduation including the completion of a course of study covering a period of not less than three school years of six months each year in actual continuous attendance covering adequate courses of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and passage of an examination prescribed by the State's chiropractic examiners covering said subjects. Moreover, the committee does not intend that the practice of operative surgery, osteopathy, or administering or prescription of any drug or medicine included in material medica should be covered by the practice of chiropractic. Such standards would also be applicable to coverage of chiropractic services under medicaid.

The services furnished by chiropractors would be covered under the program as "physicians' services," but only with respect to treatment of the spine by means of manual manipulation which the chiropractor is legally authorized to perform. As with other program benefits, the committee is aware of the possible overutilization of chiropractic services, and expects that the Secretary will issue guidelines to medicare carriers for use in review of bills for such services, to assure proper usage of the benefit.

The amendment would become effective with respect to services provided on and after July 1, 1971.

CONFORM MEDICARE AND MEDICAID STANDARDS FOR NURSING FACILITIES

(Sec. 240 of the bill)

At the present time, the conditions of participation for extended care facilities under medicare and the standards required of skilled nursing homes under medicaid are identical in some respects and similar in others. In large part, medicaid skilled nursing homes were substantially upgraded as a consequence of the specific statutory requirements applicable to such homes which were included in the Social Security Amendments of 1967.

While the emphasis of the care under the two programs may differ somewhat—medicare focusing on the short-term care patient and medicaid on the long-term patient—patients under both plans require the availability of essentially the same types of services and are often in the same institution. Indeed, not infrequently, after expiration of medicare benefits, the patient may remain in the same facility—even in the same room—continuing on as a medicaid recipient.

Because of the substantial similarities in the services required of skilled nursing facilities under the two programs, the existence of

separate requirements (which may differ only slightly) and separate certification processes for determining institutional eligibility to participate in either program, is both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved to provide care under both medicare and medicaid.

The committee believes it would be desirable to apply a single set of standards relative to health, safety, environmental conditions, and staffing, with respect to skilled nursing facilities under both medicare and medicaid. As provided in the House bill, States would also be expected to consolidate certification activities for both programs in a single State agency. The committee intends that the single State agency carry out its responsibilities to the greatest extent possible through means of a single consolidated survey to determine a facility's qualifications for medicare and medicaid.

The committee amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities. For that reason, the amendment provides that a higher standard as judged by the Secretary of Health, Education, and Welfare in one program—whether the standard is a current requirement or one required in the future—shall be applicable to the other program as well. Any waiver of a standard applicable to both programs may be applied only if acceptable under both programs. Additionally, a State may continue to require higher standards of skilled nursing facilities than those mandated by Federal statute and regulation. In case a State imposes additional requirements in its own right, then, as under present section 1863 of the Social Security Act, those standards shall apply to both medicare and medicaid skilled nursing facilities in that State.

The above provisions are effective July 1, 1971.

PROVIDE FOR SIMPLIFIED AND MORE ECONOMICAL REIMBURSEMENT OF EXTENDED CARE FACILITIES

(Sec. 241 of the bill)

Under present law, extended care facilities, as well as other providers of service, are reimbursed for the reasonable cost of covered services furnished to medicare beneficiaries. Since actual cost cannot be accurately determined until after the close of an accounting period, a facility is reimbursed with interim payments based upon its estimated costs. However, upon analysis of an annual cost report submitted by providers which identifies the actual costs incurred through cost finding and cost apportionment, a retroactive adjustment is made for any difference between the interim payments made and the program's share of the provider's actual costs, to the extent they are deemed reasonable.

Under medicaid, States generally establish (in advance) per diem or similar basic rates payable for patients receiving skilled nursing home care. Such rates ordinarily reflect estimates of the costs of providing routinely required care to eligible recipients.

The committee recognizes that the existing reasonable cost approach of the medicare program has created certain difficulties for extended care facilities. It is aware that complaints have been voiced about the complexity of medicare cost-finding and recordkeeping requirements and that problems might result from the standpoint of effective

financial management because of the facility's failure to know in advance the actual payments that will be received. The committee is also cognizant of the fact that the existing reimbursement formula, as applied, with its retrospective adjustment provision, may offer little or no incentive to contain costs or to control the type and extent of services furnished since actual costs incurred are almost always reimbursed.

On the other hand, under the medicaid program States generally establish (in advance) per diem or monthly rates for patients receiving skilled nursing care. These facilities generally know in advance the income they can expect to derive from services furnished to eligible patients and this knowledge probably contributes to more effective budgeting and planning.

The type of facility, requirements for participation, and range of services provided, do not differ substantially as between a fully qualified extended care facility in medicare and a fully qualified skilled nursing home in medicaid.

The committee bill, therefore, authorizes the Secretary to apply, in establishing reasonable cost payments for extended care facilities for any State (on a total, class, size, or other appropriate basis) the rates developed in the State under medicaid for basic reimbursement of skilled nursing care, provided he finds, based upon information and data supplied by a State, that such rates are reasonably related to the costs of care (room, board, routine nursing and other routine services) in facilities generally comparable to those participating in medicare.

The committee recognizes that various types of reimbursement methods developed by States under medicaid might be found to satisfy the above requirement where they are based upon estimates (through sampling or other techniques) of the costs of skilled nursing care in comparable facilities. For example, although frequently a single or overall State rate of reimbursement for skilled nursing care covered by medicaid is established, in some States varying rates of reimbursement are established for different categories of institutions or for different classes of patients. In other States, actual costs are reimbursed subject to certain maximum limitations. In each of these the State rates may or may not be reasonably related to the cost of services in groups of facilities participating in medicare.

Where a State's basic rates of reimbursement for skilled nursing care under medicaid are predicated upon analyses of costs for care in such facilities and the Secretary is satisfied that the analyses undertaken by the State adequately reflect the reasonable costs of care, reimbursement for posthospital extended care under medicare should be based upon or limited to the same rates of payment. The criterion to be applied by the Secretary is that the State's rates of payment be appropriately related to reasonable costs. The Secretary would be permitted to adjust a rate where appropriate, to reimburse for specific factors related to medicare requirements (such as bed availability, type of occupancy covered, any additional administrative costs) which are not considered by the State or included in the computation of its medicaid rates. Such adjustments would be distilled into a percentage factor (not in excess of 10 percent) so as to simplify reimbursement. Thus, conceivably, where facilities in a State demon-

strate to the Secretary and the State advises that medicaid in that State compensates on a basis of more patients in a room than does medicare or does not include payment for a service covered by medicare, he might reimburse such institutions on the basis of the medicaid rate plus a percentage adjustment. These percentage adjustments should be made on a geographic basis or on the basis of classes of facilities and not on an institution-by-institution basis.

Where a skilled nursing facility is a distinct part of, or directly operated by a hospital, reimbursement would be made for care in such facilities in the same manner as is applicable to the hospital's costs. Where a skilled nursing facility functions in a close formal medical satellite relationship with a hospital (which would be defined in regulations of the Secretary) reimbursement would be made on the basis of costs not to exceed 150 percent of the adjusted medicaid rates of payment (if the Secretary applies such rates to medicare facilities in that State) for care in that facility (or comparable facility).

This approach avoids substantial auditing and cost-finding expense and provides a means of making equitable adjustments where appropriate.

A facility located in a State whose medicaid rates of reimbursement for skilled nursing care are not adopted by the Secretary on a total, class, size, or other appropriate basis applicable to that facility will continue to be reimbursed under normal medicare methods.

The amendment would be effective with respect to accounting periods beginning on or after July 1, 1971.

PROVIDE FOR REASONABLE APPROVAL OF RURAL HOSPITALS

(Sec. 242 of the bill)

According to policy established by the Social Security Administration, a hospital or extended care facility is certified for participation in medicare if it is in full compliance (meets all the requirements of the Social Security Act and is in accordance with all regulatory requirements for participation), or if it is in "substantial" compliance (meets all the statutory requirements and the most important regulatory conditions for participation). Thus, while an institution may be deficient with respect to one or more standards of participation, it may still be found to be in substantial compliance, if the deficiencies do not represent a hazard to patient health or safety, and efforts are being made to correct the deficiencies.

It has been recognized that there is a need to assure continuing availability of medicare-covered institutional care in rural areas, many of which may have only one hospital, without jeopardizing the health and safety of patients. To achieve this objective, the approach has been adopted by Social Security of certifying "access" hospitals while documenting their deficiencies and requiring upgrading of plant and staff. State agencies have also been required to provide consultation and assistance to these facilities in an effort to help them achieve compliance with the standards. Certain "access" hospitals, to the extent that they are capable, have succeeded in overcoming deficiencies; however, other hospitals have not demonstrated sufficient willingness to take the steps necessary to correct deficiencies and have instead

been willing to continue as "access" hospitals with all the limitations in quality care that this status entails. In other areas, some rural hospitals despite good faith efforts have been unable to secure required personnel or otherwise comply.

To deal with the dilemma created by the need to assure the availability of hospital services of adequate quality in rural areas and the fact that existing shortages of qualified nursing personnel generally make it difficult for some rural hospitals to meet the nursing staff requirements of present law, the committee's bill would authorize the Secretary, under certain conditions, to waive the requirement that an access hospital have registered professional nurses on duty around the clock. This requirement could be waived only if the Secretary finds that the hospital:

(a) has a registered nurse at least on the daytime shift and has made and is continuing to make a bona fide effort to comply with the registered nursing staff requirement with respect to other shifts (which, in the absence of an R.N., are covered by licensed practical nurses) but is unable to employ the qualified personnel necessary because of nursing personnel shortages in the area; and

(b) is located in an isolated geographical area in which hospital facilities are in short supply and the closest other facilities are not readily accessible to people of the area; and

(c) nonparticipation of the "access" hospital would seriously reduce the availability of hospital services to medicare beneficiaries residing in the area.

Under the provision, the Secretary would regularly review the situation with respect to each hospital, and the waiver would be granted on an annual basis for not more than a one-year period. The waiver authority would be applicable only with respect to the nursing staff requirement; no waiver authority would be provided under the amendment with respect to any other conditions of participation relating to health and safety.

The proposed waiver authority would expire December 31, 1975.

INTERMEDIATE CARE FACILITIES

(Secs. 243 and 269 of the bill)

In order to provide a less costly institutional alternative to skilled nursing home care, the committee and the Congress approved in 1967 an amendment to title XI of the Social Security Act which authorized Federal matching for a new classification of care provided in "intermediate care facilities." The provision was intended to provide a means for appropriate placement of patients professionally determined to be in need of health-related supportive institutional care but not care at the skilled nursing home, or mental hospital level.

The intermediate care benefit was not intended to cover care which was essentially residential or boarding home in nature. It was not intended to provide a refuge for substandard nursing homes which would not or could not meet medicaid standards. It was not intended as a placement device whereby States could reduce costs through wholesale and indiscriminate transfer of patients from skilled nursing homes to intermediate care without careful and independent medical review of each patient's health care needs.

Many thousands of patients are in skilled nursing homes who do not need that level of care, according to recent General Accounting Office and HEW audit reports. Thousands of those people are in skilled nursing homes because their States have not as yet established intermediate care programs.

The committee has therefore, included an amendment to clarify congressional intent with respect to intermediate care and to make such care, where appropriate, more generally available as an alternative to costlier skilled nursing home or hospital care.

The committee amendment is designed to make it clear that intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital.

The committee amendment would require an intermediate care facility to have at least one full-time licensed practical nurse on its staff and to meet such other standards, prescribed by the Secretary, as are deemed necessary to assist in meeting the needs of the types of patients expected to be placed in such institutions.

The amendment also provides for the transfer of the intermediate care provisions from title XI of the Social Security Act to title XIX (medicaid). This action will enable the medically indigent, presently ineligible for intermediate care, to receive such care when it has been determined as appropriate to their health care needs. This change should also serve to end the practice, in some States, of keeping medically indigent patients in skilled nursing homes where they could more appropriately be cared for in intermediate care facilities. Such States do so because, under present law, Federal matching funds are available toward the costs of skilled nursing home care provided medically indigent persons but not for care of those people in intermediate care facilities.

The committee amendment would also authorize Federal matching under medicaid for care of the mentally retarded in public institutions which are classified as intermediate care facilities. Matching would be available only in a properly qualified institution meeting standards (in addition to those required of an ICF) established by the Department for mentally retarded persons (other than those primarily receiving custodial care) receiving an active program of health-related treatment or rehabilitation. States would not be eligible for the additional Federal matching funds unless they maintained the level of State and local funds expended for care of the mentally retarded. The purpose here is to improve medical care and treatment of the mentally retarded rather than to simply substitute Federal dollars for State dollars.

The committee agrees with the House of Representatives that intermediate care is by definition less extensive than skilled nursing home care and that the cost of intermediate care should generally be significantly less per diem than skilled nursing home care in the same area.

In view of the rapidly increasing expenditures for intermediate care and in view of the extension of intermediate care to the medically-indigent, the committee has added another provision to its amend-

ment requiring regular independent professional review of patients in intermediate care facilities. Teams, headed by either a physician or a registered nurse, would regularly review, on site, the nature of the care required and provided to each intermediate care recipient. That review would be undertaken on a patient-by-patient basis and may not be performed at a distance or without reference to the specific circumstances of the individual patient.

The committee reiterates the concern it has previously expressed with respect to the failure of many States to properly undertake the independent medical audit of skilled nursing home and mental hospital patients to assure that each patient for whom Federal funds is provided is in the right place at the right time receiving the right care. This shortcoming among the States has characterized placement and review of intermediate care patients heretofore. Each skilled nursing home, each mental hospital patient, and each intermediate care patient must be individually reviewed by an independent team to assure proper placement. Wholesale and general review for purposes of what is virtually cursory compliance with Federal requirements must not be permitted by the Department of Health, Education, and Welfare. Where such independent audits and other utilization review requirements are not properly carried out, the committee expects that the Secretary will, in accordance with section 225 of the bill, promptly act to reduce Federal matching rates toward costs of the institutional care involved until proper compliance is forthcoming from a State.

The amendment is effective July 1, 1971.

DIRECT LABORATORY BILLING OF PATIENTS

(Sec. 244 of the bill)

Payment under medicare for low cost diagnostic laboratory tests covered under the supplementary medical insurance program presents a problem when patients are billed directly for such services by the laboratory and assign their claims for medicare payment of a portion of the cost of the laboratory. The problem is that the cost of collection of an individual bill is large compared with the amount of the bill, particularly with respect to collection of the coinsurance portion. For example, where a bill for a laboratory service is \$1.50, medicare will pay only 80 percent, or \$1.20, and the laboratory must bill the patient for the 30 cents coinsurance for which he is responsible. The cost to the laboratory may exceed 30 cents, a situation which might result in the laboratory raising its fee for such service to \$2.00, so that it could collect its full charge from medicare without billing the patient.

The committee therefore added a provision to the House bill, with respect to diagnostic laboratory tests for which payment is to be made to the laboratory, so that the Secretary be authorized to negotiate a payment rate with the laboratory which would be considered the full charge for such tests, for which reimbursement would be made at 100 percent of such negotiated rate. However, such negotiated rate would be limited to an amount not to exceed the total payment that would have been made in the absence of such rate.

The amendment is effective upon enactment.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

(Sec. 245 of the bill)

INTRODUCTION

According to the most recent estimates the costs of the medicare hospital insurance program will overrun the estimates made in 1967, by \$216 billion over a 25-year period. The monthly premium costs for part B of medicare—doctors' bills—rose from a total of \$6 monthly per person on July 1, 1966, to \$10.60 per person on July 1, 1970. Medicaid costs are also rising at similar precipitous rates.

The rapidly increasing costs of these programs are attributable to two factors. One of these is an increase in the unit cost of services such as physicians' visits, surgical procedures, and hospital days. The House bill contains a number of desirable provisions which the Committee on Finance believes will be successful in helping to moderate these unit costs.

The second factor which is responsible for the increase in the costs of the medicare and medicaid programs is an increase in the number of services provided to beneficiaries. The Committee on Finance has focused its attention on methods of assuring proper utilization of these services. The committee feels that utilization controls are particularly important in light of the hearings conducted by the Subcommittee on medicare and medicaid. A number of witnesses testified that a significant number of the health services provided under medicare and medicaid are in excess of those which would be found medically necessary. In view of the per diem costs of hospital and nursing home care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from its economic impact the committee is also concerned about the effect of overutilization on the health of the aged and the poor. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care.

REVIEW OF PRESENT UTILIZATION CONTROLS

The committee has found that present utilization review requirements and activities are not adequate.

Under present law, utilization review by physician staff committees in hospitals and extended care facilities and claims review by medicare carriers and intermediaries is required. These processes have a number of inherent defects. Review activities are not coordinated between medicare and medicaid. Present processes do not provide for an integrated review of all covered institutional and noninstitutional services which a beneficiary may receive. The reviews are not based upon adequately developed norms of care. Additionally, there is insufficient professional participation, in, and support of, claims review by carriers and intermediaries and consequently there is only limited acceptance of their review activities. With respect to the quality of care provided, only institutional services are subject to quality control under medicare, and then only indirectly through the application of conditions of participation.

Under present law, each hospital and extended care facility must have a utilization review plan covering services provided to medicare patients which provides for review, on a sample or other basis, of admissions, duration of stays, and the professional services furnished. The review is to include consideration as to the medical necessity of the services and the efficient use of health facilities and services. The utilization review is undertaken by either (1) a group, including at least two physicians, organized within the institution or (2) a group (including at least two physicians) organized by a local medical society or other group approved by the Secretary of Health, Education, and Welfare. The statute provides also that the utilization review group must be organized as in (2) above, if the institution is small or for such other good reasons as may be included in regulations. The utilization review group must also review long-stay cases and inform those concerned (including the attending physician) when it determines that hospitalization or extended care is no longer medically necessary.

The Finance Committee and the Ways and Means Committee stressed in 1965 that these requirements, if effectively carried out, would discourage improper and unnecessary utilization. The Finance Committee Report (S. Rept. 404, pt. I, 89th Cong., p. 47) stated:

The committee is particularly concerned that the utilization and review function is carried out in a manner which protects the patients while at the same time making certain that they remain in the hospital only so long as is necessary, and that every effort be made to move them from the hospital to other facilities which can provide less expensive, but equal, care to meet their current medical needs.

The detailed information which the committee has collected and developed indicates clearly that utilization review activities have, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. The present situation has been aptly described by a State medical society in these words:

Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token.

Based on a sample of hospitals conducted in the middle of 1968, the Social Security Administration found:

(1) Ten percent of the hospitals were not conducting a review of extended-stay cases.

(2) Forty-seven percent of hospitals were not reviewing any sample of admissions (a basic statutory requirement).

(3) Forty-two percent of hospitals did not even maintain an abstract of the medical record or other summary form which could provide a basis for evaluating utilization by diagnosis or other common factor.

In one State, the health agency conducted a detailed program review in November 1968. Their findings were that half of the hospitals and all of the extended-care facilities failed to perform any sample review of cases which were not in the long-stay category (a statutory requirement).

The current statute places upon the intermediary as well as the State health agency responsibility for assuring that participating hospitals and extended-care facilities effectively perform utilization review.

Available data indicates that in many cases intermediaries have not been performing these functions, despite the fact that the Secretary may not, under the law, make agreements with an intermediary who is unwilling, or unable, to assist providers of services with utilization review functions.

Apart from the problems experienced in connection with their determinations of "reasonable" charges, the performance of the carriers responsible for payment for physicians' services under medicare has also varied widely in terms of evaluating the medical necessity and appropriateness of such services. Moreover, ever since medicare began, physicians have expressed resentment that their medical determinations are challenged by insurance company personnel. The committee has concluded that the present system of assuring proper utilization of institutional and physicians' services is basically inadequate. The blame must be shared between failings in the statutory requirements and the willingness and capacity of those responsible for implementing what is required by present law.

There is no question, however, that the Government has a responsibility to establish mechanisms capable of assuring effective utilization review. Its responsibility is to the millions of persons dependent upon medicare and medicaid, to the taxpayers who bear the burden of billions of dollars in annual program costs, and to the health care system.

In light of the shortcomings outlined above, the committee feels that the critically important utilization review process must be restructured and made more effective through substantially increased professional participation.

The committee believes that the review process must be based on the premise that only physicians can judge whether services ordered by other physicians are necessary. The committee is aware of increasing instances of criticism directed at the use of insurance company personnel and Government employees in reviewing the medical necessity of services.

The committee generally agrees with the principles of "peer review" enunciated in the report of the President's Health Manpower Commission, issued in November 1967. That report stated:

Peer review should be performed at the local level with professional societies acting as sponsors and supervisors.

Assurance must be provided that the evaluation groups perform their tasks in an impartial and effective manner.

Emphasis should be placed on assuring high quality of performance and on discovering and preventing unsatisfactory performance.

The more objective the quality evaluation procedures, the more effective the review bodies can be. To enable greater objectivity, there should be a substantial program of research to develop improved criteria for evaluation, data collection methods, and techniques of analysis.¹

¹ Report of the Health Manpower Commission, November 1967, p. 48.

THE COMMITTEE PROVISION

The committee has provided for a review mechanism through which practicing physicians can assume full responsibility for reviewing the utilization of services. The committee's review mechanism would at the same time contain numerous safeguards intended to fully protect the public interest.

The committee provision would establish broadly based review organizations with responsibility for the review of both institutional and outpatient services, as opposed to the present fragmented review responsibilities.

The new review organizations would be large enough to take full advantage of rapidly evolving computer technology, and to minimize the inherent conflicts of interest which have been partially responsible for the failure of the smaller institutionally based review organizations. The review process would be made more sophisticated through the use of professionally developed regional norms of care as guidelines for review activities, as opposed to the present usage of arbitrarily determined checkpoints. The present review process, without norms, becomes a long series of episodic case-by-case analyses on a subjective basis which fail to take into account in a systematic fashion the experience gained through past reviews. The committee believes that the goals of the review process can be better achieved through the use of norms which reflect prior review experience.

The committee's bill provides specifically for the establishment of independent professional standards review organizations (PSRO's) formed by organizations representing substantial numbers of practicing physicians in local areas to assume responsibility for the review of services (but not payments) provided through the medicare and medicaid programs. The Department of Health, Education, and Welfare endorses this change in law.

Recognizing the problem, on their own, a number of medical societies and other health care organizations have already sponsored similar types of mechanisms for purposes of undertaking unified and coordinated review of the total range of health care provided patients. Additional medical societies are proceeding to set up such organizations (usually called foundations).

However, in most parts of the country, new organizations would need to be developed.

The committee would stress that physicians—preferably through organizations sponsored by their local associations—should assume responsibility for the professional review activities. Medicine, as a profession, should accept the task of advising the individual physician where his pattern of practice indicates that he is overutilizing hospital or nursing home services, overtreating his patients, or performing unnecessary surgery.

It is preferable and appropriate that organizations of professionals undertake review of members of their profession rather than for Government to assume that role. The inquiry of the committee into medicare and medicaid indicates that Government is ill equipped to assure adequate utilization review. Indeed, in the committee's opinion, Government should not have to review medical determinations unless the medical profession evidences an unwillingness to properly assume the task.

But, the committee does not intend any abdication of public responsibility or accountability in recommending the professional standards review organizations approach. While persuaded that comprehensive review through a unified mechanism is necessary and that it should be done through usage, wherever possible and wherever feasible, of medical organizations, the committee would not preclude other arrangements being made by the Secretary of Health, Education, and Welfare where medical organizations are unwilling or unable to assume the required work or where such organizations function not as an effective professional effort to assure proper utilization and quality of care but rather as a token buffer designed to create an illusion of professional concern.

In a number of areas of the country, carriers and intermediaries—even though their activity is limited to retrospective review—are doing a reasonably effective job of controlling overutilization and unnecessary utilization of health care services. Such efforts should not be terminated in any area until such time as a professional standards review organization has satisfactorily demonstrated the willingness, operational capacity, and performance to effectively supplant and improve upon existing review work. Even where the PSRO becomes the paramount review organization, the existing review, if it is efficient and effective, should not be dismantled, if the PSRO can benefit by utilizing its experience and services.

Additionally, the committee was impressed with the scope and results of the review activity and quality control efforts of the New York City Department of Health with respect to medicaid. While professional standards review organizations should be given priority in undertaking review responsibility, the present activities of the New York City Department of Health, and similar public agencies should not be terminated, or otherwise limited, until such time as professional standards review mechanisms are functioning at least equally as effectively as those of the public agencies. Again, to the extent the PSRO and the medicare program can benefit from utilizing the services of such an organization, the PSRO would be empowered to continue its effectiveness.

ESTABLISHMENT OF PSRO'S

The amendment requires the Secretary of HEW, following consultation with national, State and local, public and private medical care organizations, and medical societies, to tentatively designate PSRO areas throughout the country by January 1, 1972. In smaller or more sparsely populated States, the designations would probably be on a statewide basis. Each area, defined in geographic or medical service area terms, would generally include a minimum of 300 practicing physicians—in many cases substantially more than that number. Because of the minimum number of physicians required—intended to assure broad, diverse, and objective representation—it is expected that there will be many multicounty PSRO areas.

Tentative area designations could be modified if, as the system was placed into operation, changes seemed desirable. The Secretary would provide prototype plans of organization and operation to prospective PSRO's in each area. The prototypes would be developed in consulta-

tion with proposed PSRO's and with various organizations presently operating comprehensive review mechanisms as well as national, State and local, private and public, health organizations.

Priority in designation as a PSRO would be given to organizations established at local levels representing substantial numbers of practicing physicians who are willing and believed capable of progressively assuming responsibility for overall continuing review of institutional and outpatient care and services. Local sponsorship and operation should help engender confidence in the familiarity of the review group with norms of medical practice in the area as well as in their knowledge of available health care resources and facilities. Furthermore, to the extent that review is employed today, it is usually at the local level. To be approved, a PSRO applicant must provide for the broadest possible involvement, as reviewers on a rotating basis, of physicians engaged in all types of practice in an area such as solo, group, hospital, medical school, and so forth.

Participation in a PSRO should be voluntary and open to every physician in the area. Existing organizations of physicians should be encouraged to take the lead in urging all their members to participate but no physician should be barred from participation because he is or is not a member of any organized medical group or be required to join any such group or pay dues or their equivalent for the privilege of becoming a member of any PSRO nor should there be any discrimination in assignments to perform PSRO duties based on membership or non-membership in any such organized group of physicians.

Physician organizations or groupings would be completely free to undertake or to decline assumption of the responsibilities of organizing a PSRO. If they decline, the Secretary would be empowered to seek alternative applicants from among other medical organizations, State and local health departments, medical schools, and failing all else, carriers and intermediaries or other health insurers. In no case, however, could any organization be designated as a PSRO which did not have professional medical competence. And, in no case could any final adverse determinations by a PSRO with respect to the conduct or provision of care by a physician be made by anyone except another qualified physician.

PSRO physicians engaged in the review of the medical necessity for hospital care and justification of need for continued hospital care must be active hospital staff members. The purpose here is to assure that only doctors knowledgeable in the provision and practice of hospital care will review such care. To the maximum extent feasible, it is intended that a physician not be involved in the review of care for the PSRO which was provided in a hospital where he has active staff privileges (except to the extent of his involvement with "in-house" review acceptable to the PSRO).

The committee expects that the Secretary of HEW will provide every possible assistance to the PSRO's. The Department would be required to develop prototype review plans and would be expected to provide assistance and encouragement in the development of acceptable review plans. Proposals submitted to the Secretary by prospective PSRO's would be made available, on request, to appropriate concerned organizations and individuals who, in turn, would be free to submit to the Secretary such comments on the proposal as

might assist his evaluation of the prospective PSRO. The Department would also be required to develop the capacity to evaluate the potential of review plans proposed by organizations throughout the country, and with the assistance and advice of the National Professional Standards Review Council, to monitor on a regular and continuing basis the performance of the organizations selected through the use of statistical comparisons and other means of evaluation.

The committee recognizes that proper administration of this provision will involve substantial administrative effort and expense. However, over the long run, the PSRO provision, properly implemented, should result in substantial reductions in program costs. The Secretary is expected to take such administrative steps and provide all necessary assistance and cooperation to assure that no PSRO fails because it does not have the means or information required to perform adequately.

CONDITIONAL STATUS OF PSRO'S

A qualified PSRO applicant would be approved on a conditional basis for a period of approximately 2 years during which it would develop and expand its review activities and capacity. During the conditional period, existing medicare and medicaid review operations would also continue so as to provide backup and standby capacity in the event a PSRO encounters difficulties or is terminated. At the end of the conditional period, where the PSRO has satisfactorily demonstrated its effectiveness in review, the Secretary would have authority to waive any other professional review requirements imposed under the law and regulations.

Medicare and medicaid claims-paying agencies would be expected to abide by final decisions of the PSRO during this trial period. Placing reliance on the PSRO decision during the trial period is necessary to permit an accurate appraisal of the effectiveness with which the conditionally approved PSRO's could be expected to exercise the review function in the absence of concurrent review by others.

As noted, once an organization is accepted as a PSRO the Secretary would regularly evaluate its performance using statistical comparison and other means of evaluation including the findings and recommendations of the statewide and national professional standards review councils established under the amendment. Where performance of an organization was determined to be unsatisfactory, and timely efforts to bring about its improvement failed, the Secretary could terminate its participation after appropriate notice and opportunity for administrative hearing. A finding, for example, that one PSRO was accepting without question substantial numbers of requests which other apparently well-run PSRO's were generally investigating and denying would be expected to result in termination of the agreement with the former PSRO unless the situation is justified by factors related to medical necessity or unless reasonable action to correct the problem is undertaken.

The committee anticipates that professional standards review organizations will function in effective and dedicated fashion under the guidance of concerned physicians. In instances where there might be

only nominal or half hearted performance, it would be expected that necessary remedial action would be promptly taken through the initiative of the medical profession and, failing that, by the Secretary of Health, Education, and Welfare.

If the Secretary found it necessary to replace a review organization, as a first step he would consult with other review organizations in the State involved as well as with the State medical society to determine whether another local organization or an organization sponsored by the State society itself was willing and capable of undertaking review responsibility in the geographic area concerned. In the event that such was not the case, he could then contract with State or local health departments or employ other suitable professional means of assuring the necessary review activity in the area.

RESPONSIBILITIES OF A PSRO

A professional standards review organization would have the responsibility of determining—for purposes of eligibility for medicare and medicaid reimbursement—whether care and services provided were: first, medically necessary, and second, provided in accordance with professional standards. Additionally, the PSRO where medically appropriate, would encourage the attending physician to utilize less costly alternative sites and modes of treatment. The PSRO would not be involved with questions concerning the reasonableness of charges or costs or methods of payment nor would it be concerned with internal questions relating to matters of managerial efficiency in hospitals or nursing homes except to the extent that such questions substantially affect patterns of utilization. The PSRO's responsibilities are confined to evaluating the appropriateness of medical determinations so that medicare and medicaid payments will be made only for medically necessary services which are provided in accordance with professional standards of care.

The local professional standards review organization would be primarily responsible for review of all medicare and medicaid services rendered or ordered by physicians in its area. The purpose of the provision is to establish a unified review mechanism for all health care services under the aegis of the principal element in the health care equation, the physician. Christian Science practice, however, would not be encompassed in the overall review and review arrangements required of a PSRO.

In carrying out its responsibilities the PSRO would be required to regularly review provider and practitioner profiles of care and service (that is, the patterns of services delivered to medicare and medicaid beneficiaries by individual health care practitioners and institutions) and other data to evaluate the necessity, quality, and appropriateness of services for which payment may be made under the medicare and medicaid programs.

The PSRO would be expected to analyze the pattern of services rendered or ordered by individual practitioners and providers and to concentrate its attention on situations in which unnecessary, substandard, or inappropriate services seem most likely to exist or occur. Emphasis in review efforts would be related to the results expected to be achieved by these efforts so that the net advantage from the review time would be maximized.

The Secretary would be responsible for determining the most efficient means of developing the profiles of services and other necessary data required.

A PSRO would have authority to approve the medical necessity of all elective hospital admissions in advance—solely for the purpose of determining whether medicare or medicaid will pay for the care. The PSRO would be authorized to acknowledge and accept, in whole or in part, an individual hospital's own review of admissions and need for continued care, on a hospital-by-hospital basis, where it has determined that a hospital's "in-house" review is effective. It is expected that where such "in-house" review is effective this authority would be exercised by the PSRO. Similarly, a Professional Standards Review Organization would be authorized to acknowledge and accept for its purposes, review activities of local medical societies, or other medical organizations, including those internal review activities of comprehensive prepaid group practice programs such as the Kaiser Health plans and the Health Insurance Plan (H.I.P.) in New York. In order to assure the broadest possible participation in PSRO activities by physicians in an area, it is expected that internal review activities will not be accepted by a PSRO where the physicians of the institution or medical organization concerned do not participate in the overall review activities conducted by the PSRO. Thus an institution or medical organization which is carrying out effective review would bring its desirable expertise to the benefit of the entire community, to the extent that the Professional Standards Review Organization finds those review activities and experience effectively assist in fulfilling its overall responsibilities.

The purpose here is to build upon and encourage improvement in existing systems of review to the extent those systems are capable of assisting in fulfilling the overall responsibilities of a PSRO. Thus effective review mechanisms would be recognized and encouraged by the PSRO. Of course, PSRO's would use this authority carefully. Indiscriminate acceptance of hospital and other review activities would undoubtedly be reflected in an overall poor performance rating when a PSRO was measured against other PSRO's operating in careful fashion. A poor rating could, in turn, lead to termination and replacement of the negligent PSRO. Where advance approval was required and provision of services was disapproved in advance of admission by the PSRO, payment for the services could not be made under medicare or medicaid (unless the disapproval was reversed in the course of reconsideration, hearing, or court review). In case of advance review the institution and the patient alike would know in advance whether medicare will pay for the health care services being contemplated although denial of certification for admission would not bar admission of any patient to an institution if his physician desires to admit him and if the institution accepts his admission. In this regard, medicare parallels private health insurance where a private policy issuer might determine that the care proposed or rendered was not reimbursable under the terms of the policy. In such cases, the provider or practitioner looks to the policyholder for payment directly.

Where advance approval by the review organizations for institutional admission was required and provision of the services was approved by the PSRO, such approval would provide the basis for a

presumption of medical necessity for purposes of medicare and medic-aid benefit payments. However, advance approval of institutional admission would not preclude a retroactive finding that ancillary services (not specifically approved in advance) provided during the covered stay were excessive.

The PSRO, where it has not accepted in-house review in a given hospital as adequate, would be responsible for reviewing certifications of need for continued hospital care beyond professionally determined regional norms directly related to patients' age and diagnoses, using criteria such as the types of data developed by the Commission on Professional and Hospital Activities, which is sponsored by the American Hospital Association, the American College of Physicians, and the American College of Surgeons. It is expected that such certification would generally be required not later than the point where 50 percent of patients with similar diagnoses and in the same age groups have usually been discharged. However, it is recognized that there are situations in which such stays for certain diagnoses may be quite short in duration. In such situations the PSRO might decide against requiring certification at or before the expiration of the period of usual lengths of stay on the grounds that the certification would be unproductive; for example, when the usual duration of stay is two days or less. Certification on the first day of stay might yield no significant advantage in the review process.

This professionally determined time of certification of need for continued care is a logical checkpoint for the attending physician and is not to be construed as a barrier to further necessary hospital care. Neither should the use of norms as checkpoints, nor any other activity of the PSRO, be used to stifle innovative medical practice or procedures. The intent is not conformism in medical practice—the objective is reasonableness.

PSRO disapproval of the medical necessity for continued hospital care beyond the norm for that diagnosis will not mean that the physician must discharge his patient. The physician's authority to decide the date of discharge as well as whether his patient should be admitted in the first place cannot be and are not taken from him by the PSRO. The review responsibility of the PSRO is to determine whether the care should be paid for by medicare and medicaid. By making this determination in advance the patient, the institution, and the physician will all be forewarned of the desirability of making alternative plans for financing the care being contemplated.

OPERATION OF A PSRO

It is expected that a PSRO would operate in a manner which conserves and maximizes the productivity of physician review time without unduly imposing on his principal function. the provision of health care services to his own patients. One way to conserve physician review time is through automated screening of claims by computers and other devices used in the claims process carried out under specifications set forth by the PSRO. Another way to conserve physician time would be through the use of other qualified personnel such as registered nurses who could, under the direction and control of PSRO physicians, aid in assuring effective and timely review.

And as already pointed out, a third is by utilizing the services of active and conscientious utilization review committees in hospitals and in local medical organizations.

It is expected that the Secretary will develop necessary procedures for coordination between medicaid agencies, medicare carriers and intermediaries and the PSRO's. The profiles presently maintained under existing regulations by the State agencies, carriers and intermediaries would be made available to the PSRO's. Following completion of the conditional period of PSRO designation the Secretary would be authorized to waive any control or review activity required by law which he determines to be unnecessary in view of the review and control activities assumed by and effectively performed by a PSRO. Thus, the PSRO activity would be fitted into the medicare-medicaid process with an eye to efficiency in the system.

Existing medical organizations, such as the San Joaquin and Sacramento Medical Foundations in California, and others have developed patient and practitioner profile forms and approval certification methods which may provide the bases for development of uniform data gathering and review procedures capable of being employed in many areas of the Nation. The committee expects that the Secretary in conjunction with various medical and other organizations, would assist the local professional standards review organizations through providing them with model operational guides, forms and methodology descriptions. To the greatest extent possible, standardized forms and procedures should be utilized by the local review organizations. Of course, this approach would not preclude acceptable modification and adaptation to meet local circumstances, but basic formats should be established for national usage and basic comparable data for inter-PSRO comparisons should be developed.

It is expected that economical and efficient computer and other resources already existing in carriers and intermediaries would be utilized to the greatest extent feasible and that operations would be consolidated and coordinated wherever possible. In a similar fashion, the PSRO should use the established communication channels of State and local medical associations to keep practicing physicians fully informed of review activities.

The committee would stress that the approach recommended does not envisage Blue Cross or Blue Shield or other insurance organizations or hospital or medical association review committees, assuming the review responsibilities for the professional standards review organizations. Where Blue Cross or Blue Shield or other insurers, or agencies have existing computer capacity capable of producing the necessary patient, practitioner, and provide profiles on an ongoing expeditious and economical basis, it would certainly be appropriate to employ that capacity as a basic tool for the professional standards review organizations; but that mechanism would be employed essentially to feed computer printouts to the review organizations which would be responsible for their evaluation. The responsibility for handling requests for such prior approval of hospital admissions, elective procedures and services as might be required, as well as the administrative mechanism for processing such requests, would lie with the professional standards review organizations.

It is expected that PSRO's would make specific arrangements with groups representing substantial numbers of dentists for necessary review of dental services.

PSRO's would be authorized to retain and consult with other types of health care practitioners to assist in reviewing services which their fellow practitioners provide. In the event it was not feasible or appropriate to undertake review arrangements with such a group, arrangements may be made with a qualified practitioner for necessary review referrals. However, physicians should not be precluded—in fact they should be encouraged—to participate in the review of services ordered by physicians but rendered by other health care practitioners. For example, physical therapists may be utilized in the review of physical therapy services, but physicians should determine whether the services should have been ordered. The PSRO would be responsible for seeing to it that any arrangement it made was carried out effectively.

Expenses reasonably and necessarily incurred by the PSRO's, statewide councils and advisory groups and the national council would be borne by the Federal Government. Since overutilization of health services is not restricted to medicare and medicaid but affects private health insurance as well, the PSRO would be at liberty to provide its review services to private health insurers provided the additional review efforts do not deteriorate the quality of the medicare-medicoid reviews. In such a case, there would be a proportionate allocation of costs between medicare, medicaid, and others served by the review organization.

Employees of the PSRO would be selected by the organization and would not be Government employees. Where the Federal Government has paid for or supplied necessary equipment to the review organizations, title to such property would remain with the Government.

A PSRO agreement would include provision for orderly transfer of medicare and medicaid records, data and other materials developed during the trial period to the Secretary or such successor organization as he might designate in the event of termination of the initial agreement. Such transfer would involve only those records pertinent to medicare and medicaid patients and would be made solely for purposes of permitting orderly continuity of review activities by a successor PSRO.

SANCTIONS AND LIABILITY

It is anticipated that in those areas where professional standards review organizations function effectively, the need for sanctions will be minimal. However, sanctions are provided under the amendment to deter improper activity.

On the basis of its investigations of situations of possible abuse identified in its own review or referred to it by the Secretary or his administrative agents, the PSRO would (after reasonable notice and opportunity for discussion with the practitioner or provider involved) recommend to the Secretary appropriate action against persons responsible for gross or continued overuse of services, for use of services in an unnecessarily costly manner, or for inadequate quality of services and would act to the extent of its authority and influence to correct improper activities.

In determining responsibility for overuse of services, uneconomical use of services or the provision of substandard services, the PSRO would take into account actual ability of the provider or physician to control the activities in question.

Where a review organization finds that voluntary and educational efforts fail to correct or remedy an improper situation with respect to a practitioner or provider, it would transmit its recommendations concerning sanctions through the statewide council to the Secretary of HEW. Protective appeals procedures are afforded to those against whom sanctions have been recommended. Where he receives such a recommendation, the Secretary could terminate or suspend medicare and medicaid payment for the services of the practitioner or provider involved, or assess an amount reasonably related to the excessive costs to the programs deriving from the acts or conduct involved—but not to exceed \$5,000 against persons or institutions found to be at fault. In such cases the practitioner or provider would be granted a hearing by the Secretary on request and could seek judicial review of the final determination of the Secretary.

The amendment provides protection from civil liability for those engaged in required review activities, or who provide information to PSRO's in good faith, for actions taken in the proper performance of these duties. Activities taken with malice toward a practitioner or institution, or group of practitioners would not be considered action taken in the proper performance of these duties. In addition, physicians, providers, and others involved in the delivery of care, would be exempt from civil liability arising from adherence to the recommendations of the review organization provided they exercise due care in the performance of their functions. The intention of this provision in the amendment is to remove any inhibition to proper exercise of PSRO functions, or the following by practitioners and providers, of standards and norms recommended by the review organization.

Thus, a physician following practices which fall within the scope of those recommended by a PSRO would not be liable, in the absence of negligence in other respects for having done so.

Failure to order or provide care in accordance with the norms employed by the PSRO is not intended to create a legal presumption of liability.

The exemptions from civil liability would apply to a range of patterns which fall within the scope of the norm, to the extent that such a range is considered acceptable by the PSRO in accordance with regulations of the Secretary. For example, the usual length of stay for a given illness might be six days, but an individual practitioner might only hospitalize his patient for four days. In this case the doctor might be motivated to keep his patient in the hospital for an extra two days to assure himself of exemption from liability. However, as described above, the PSRO could approve a range of norms, each of which was considered medically acceptable by the PSRO which could encompass a hospital stay of four days as being sufficient. It is not intended, however, that this protection preclude the liability of any

person who is negligent in performing PSRO functions or who misapplies or causes to be misapplied the professional standards promulgated by a review organization.

A physician or provider should not be relieved of responsibility where standards or norms are followed in an inappropriate manner or where an incorrect recommendation by the PSRO is induced through provision of erroneous or incomplete information.

Objective and impartial review must be provided by a professional standards review organization if it is to be effective and respected. Malice, vendettas, or other arbitrary and discriminatory practices or policies are by definition "nonprofessional," and in the unlikely event of such occurrences the Secretary of Health, Education, and Welfare is expected to promptly act to terminate the contract with the organization involved unless it immediately undertakes voluntary corrective measures.

STATE AND NATIONAL ORGANIZATIONS

Under the amendment statewide professional standards review councils (and an advisory group to each council) would be established in States which have three or more PSRO's. A council would consist of one representative from each PSRO, two physicians designated by the State medical society, two physicians designated by the State hospital association, and four persons, knowledgeable in health care, selected by the Secretary as public representatives. Two of the public representatives would be selected from nominees recommended by the Governor of the State.

A statewide council would serve to coordinate the activities of the PSRO's within the State, disseminate information and other data to them and review the overall effectiveness of each of the PSRO's operations. The council would be advised and assisted in its activities by an advisory group consisting of representatives of health care practitioners (other than physicians) and health care institutions.

Completing the structure, a national professional standards review council would be established. That council would consist of 11 physicians of recognized standing and distinction in the review of medical practice who would be appointed by the Secretary. A majority of the members would be selected from nominees of national organizations representing practicing physicians. The council would also include physicians nominated by consumer groups and other health care interests such as hospitals. The national council would arrange for the collection and distribution of data and other information useful to the statewide and local professional standards review organizations; particularly, norms of care employed in various geographic or medical service areas and various methods of utilizing and applying those norms. The national council would also report regularly to the Secretary and to the Congress on the overall and area-by-area effectiveness of the review program and offer such recommendations as it might have for improvement of the program.

DEMONSTRATION OF PSRO UNDERWRITING

The committee amendment authorizes the Secretary on a demonstration basis to enter into agreements with willing PSRO's to test the

feasibility and potential economies which might be gained through allowing PSRO's to underwrite and assume responsibility for payment for medicare and medicaid claims. These demonstrations are worthy of trial; the arrangements are such that physicians involved would have economic incentives to practice efficiently and effectively. In a demonstration program, a PSRO would undertake responsibility for review and the arranging of payment for all care and services for which beneficiaries or recipients in its geographic area were eligible. The PSRO could be reimbursed on a capitation, prepayment, insured, or related basis. Contracts would be entered into on a 1-year renewable incentive basis.

ROLE OF THE INSPECTOR GENERAL

Properly established and properly implemented throughout the Nation, professional standards review mechanisms can help relieve the tremendous strain which soaring health costs are placing upon the entire population. Emphasis, wherever possible, upon the provision of necessary care on an outpatient rather than inpatient basis could operate to reduce need for new construction of costly hospital facilities. Hospital bed need would be further reduced by reductions in lengths of hospital stay and avoidance of admission for unnecessary or avoidable hospitalization.

To be effective, the Professional Standards Review Organization provisions will require full and forthright implementation. Equivocation, hesitance, and half-hearted compliance will negate the intended results from delegation, with appropriate public interest safeguards, of primary responsibility for professional review to nongovernmental physicians. For these reasons, the committee expects that, the Inspector General for Health Administration (whose office is established under another amendment) will give special attention to monitoring and observing the establishment and operation of the professional standards review organizations to assure conformance and compliance with congressional intent.

PROFICIENCY TESTING FOR HEALTH PERSONNEL

(Sec. 264 of the bill)

Under present law, the Secretary establishes various health and safety criteria as conditions for the participation of providers of service in the medicare program. In setting these standards it is necessary to establish criteria for judging the professional competency and qualifications of key personnel in these health facilities. Medicare and medicaid regulations have relied heavily on formal training courses and professional society membership in judging professional competency.

In the report of this committee on the Social Security Amendments of 1967, (H. R. 12080) the committee agreed with the Secretary that appropriate criteria as prima facie evidence of competence are necessary. However, the committee expressed concern that reliance solely on specific formal education or training, or membership in private professional organizations might serve to disqualify people whose work experience and training might make them equally or better qualified

than those who meet the existing requirements. The committee pointed out in 1967 that failure to make the fullest use of competent health personnel was of particular concern because of the shortage of such personnel.

In 1967, the committee recommended that the Secretary of Health, Education, and Welfare consult with appropriate professional health organizations and State health agencies and, to the extent feasible, explore, develop, and apply appropriate means—including testing procedures—for determining the proficiency of health care personnel otherwise disqualified or limited in responsibility under regulations of the Secretary. Moreover, the committee instructed the Secretary to encourage and assist programs designed to upgrade the capabilities of those not sufficiently skilled to qualify initially but who could perform satisfactorily and qualify on a proficiency basis with relatively little additional training.

However, despite that formal instruction and expectation of the committee the Department of Health, Education, and Welfare has since 1967 continued to rely almost entirely on formal training and professional society membership in measuring the qualifications of health care personnel. The Department has taken little or no action, except with respect to directors of clinical laboratories, in developing proficiency testing and training courses. The personnel problems which existed in 1967 and which the committee sought to alleviate, have been aggravated as a result of the Department's continued inaction.

The Medical Services Administration issued a ruling effective July 1, 1970, concerning licensed practical nurses in skilled nursing homes participating in medicaid. Nursing homes, according to the ruling, must have as charge nurses for each shift (other than the day shift which requires a registered nurse) a registered nurse or a licensed practical nurse, with a degree from a State-accredited school or its equivalent. There is an acute shortage of nursing personnel, and many hundreds of nursing homes have been covering some shifts with "waivered" practical nurses. These are practical nurses, who do not have the required formal training, and who, in many States, have been licensed on a waived basis. Undoubtedly, a substantial proportion of these practical nurses have years of experience and are competent; obviously, other waived practical nurses are not competent to serve as charge nurses.

As noted, the Department of Health, Education, and Welfare has taken no action since 1967, in developing proficiency testing or short-term supplemental training for these personnel, and consequently, many otherwise qualified nursing homes are being, or soon may be, forced out of the program because of their inability to locate a registered nurse or a licensed practical nurse.

Problems somewhat similar to those confronting waived licensed practical nurses exist with respect to physical therapists, medical technologists, and psychiatric technicians.

The committee has, therefore, included an amendment which requires the Secretary to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present regulations. The committee expects that the Secretary will regularly report to it and to the

Committee on Ways and Means of the House of Representatives concerning the Department's progress in this area.

The committee would emphasize again its concern that only qualified personnel be utilized in providing care under medicare and medicaid. However, appropriate methods and procedures are capable of being promptly developed and applied to determine qualifications and to upgrade skills to qualifying levels. The committee does not advocate "grandfathering" of poorly equipped health care personnel nor does it advocate usage of arbitrary and inflexible cut-off standards of qualification which rule out of program participation many competent personnel.

Determinations of proficiency will not apply with respect to personnel initially licensed by a State or seeking initial qualification as a health care person after December 31, 1975. Such individuals will be expected to meet appropriate formal training criteria. But during the 5-year duration of the program of proficiency determinations, prospective health care personnel and educational institutions should have adequate time and opportunity to plan and arrange for proper and acceptable training.

The amendment would be effective upon enactment.

INSPECTOR-GENERAL FOR HEALTH ADMINISTRATION

(Sec. 265 of the bill)

Based upon its years of inquiry and extensive examination of the medicare and medicaid programs, the committee found that these programs have suffered from the lack of a dynamic and ongoing mechanism with specific responsibility for continuing review of medicare and medicaid in terms of the effectiveness of program operations and compliance with congressional intent.

While the Comptroller General and the Department of Health, Education, and Welfare's Audit Agency have done some valuable and helpful work along the above lines, there is a pronounced need for vigorous day-to-day and month-to-month monitoring of these programs, which now cost \$15 billion annually, conducted by a unit relatively free of constant pressures from various nonpublic interests at a level which can promptly call the attention of the Secretary and the Congress to important problems and which is charged with authority to remedy such problems in timely, effective, and fully responsible fashion.

To achieve the above objectives, the committee has approved an amendment which would establish an Office of Inspector General for Health Administration in the Department of Health, Education, and Welfare.

The responsibilities and role envisaged for the Inspector General for Health Administration are essentially patterned after the successful approach employed in the Agency for International Development and the investigative and reporting responsibilities, with respect to congressional requests, required of the U.S. Tariff Commission.

The Inspector General would be provided with authority sufficient to assure that medicare and medicaid function as Congress intends.

He would be appointed or reappointed by the President with the consent of the Senate for a term of 6 years. A Deputy Inspector

General and such additional personnel as are necessary to carry out the functions of the Inspector General's office are also authorized.

The Inspector General is to report directly to the Secretary of HEW and in carrying out his responsibilities he is not to be under the control of, or subject to supervision by, any officer of HEW other than the Secretary.

The Inspector General will have the duty and responsibility of arranging, conducting, or directing reviews, investigations, inspections, and audits of medicare, medicaid, and any other programs of health care established under the Social Security Act as he considers necessary for determining—

- (a) Efficiency and economy of administration;
- (b) Consonance with provisions of law; and
- (c) The attainment of the objectives and purposes for which the provisions of law were enacted.

He will be required to maintain continuous observation and review of the programs to determine the extent to which they comply with applicable laws and regulations and to evaluate the extent to which the programs attain the legislative objectives and purposes. The Inspector General is to make recommendations for correction of deficiencies or for improving the organization, plans, procedures, or administration of the health care programs.

In carrying out his duties, the Inspector General will have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material of or available to the Department of Health, Education, and Welfare which relate to the health care programs. The head of any Federal department, agency, bureau, office, et cetera, would also, upon his request, provide any information which the Inspector General determines would assist in the carrying out of his responsibilities.

The Inspector General will have authority to suspend any regulation, practice, or procedure employed in the administration of any of the health care programs if he determines (as a result of any study, investigation, review, or audit) that the suspension will promote efficiency and economy in the administration of the program, or that the regulation, practice, or procedure involved is contrary to or does not carry out the objectives and purposes of applicable provisions of law. Any suspension would remain in effect until an order or reinstatement was issued by the Inspector General except that the Secretary might, at any time subsequent to 30 days after such suspension of a proposed regulation, issue an order revoking the suspension. The Secretary might immediately revoke (so as to render ineffective and inoperative) any suspension ordered with respect to an existing regulation.

The Inspector General could submit to the Committees on Ways and Means and Finance such reports relating to his activities as he deemed appropriate. He would, upon the request of either committee for any information, study, or investigation relating to, or within his responsibilities, cause such information to be furnished and such study or investigation to be undertaken. When the Inspector General issued any order of suspension or reinstatement, he would promptly notify the Committees on Ways and Means of the House of Representatives and the Committee on Finance of the Senate of the order, and submit to

them information explaining the reasons for suspension or lifting of suspension. Where the Secretary terminates an order of suspension issued by the Inspector General he, is required also to submit an explanation of his reasons to the two committees.

The Committee on Finance is convinced that this new office, with lines of communication direct to the Secretary of the Department and to the concerned committees of Congress, will make a major—and badly needed—contribution to the efficiency of the massive Federal health programs reflected in the medicare and medicaid statutes. Armed as he would be with authority to suspend a regulation, practice, or procedure which he finds is not in harmony with congressional intent, or which will, in his considered opinion, lead to inefficiency or waste, the voice of the Inspector General will be given great weight in the highest decision making councils of the Department.

Expenses of the Inspector General are authorized in such amounts as are necessary to carry out the purposes of the amendment with the Secretary of HEW allocating proportions of the total amount to the various health care programs and trust funds involved.

The Inspector General may make confidential expenditures of up to \$50,000 in any fiscal year, except that not more than \$2,000 may ever be paid with respect to any one individual. He would submit an annual confidential report of any such expenditures to the Committee on Finance and to the Committee on Ways and Means.

The amendment is effective upon enactment.

INCREASE IN MAXIMUM FEDERAL MEDICAID MATCHING FOR PUERTO RICO

(Sec. 266 of the bill)

At present, Federal matching funds for Puerto Rico's medicaid expenditures are at a rate of 50 percent, except that the total amount of Federal funds may not exceed \$20 million in any fiscal year.

The committee believes that the \$20 million Federal maximum on medicaid payments to Puerto Rico should be adjusted to reflect the rise in hospital and health care costs, as well as the increase in the number of persons eligible for medicaid since 1967, when the ceiling and matching rate were established.

The committee recognizes the efforts made by Puerto Rico to provide comprehensive health care. Among the 54 jurisdictions with medicaid programs, Puerto Rico ranks 13th in expenditures per inhabitant for medical assistance. Because Puerto Rico spends considerably more on its medicaid program than the \$20 million necessary to receive full Federal matching, the Federal share of Puerto Rico's title XIX program was only about 35 percent in fiscal year 1969.

The committee therefore provided that the Federal ceiling on title XIX payments to Puerto Rico be increased to \$30 million effective with fiscal year 1972 and fiscal years thereafter. The 50 percent Federal matching rate would remain unchanged.

EARLY AND PERIODIC DIAGNOSIS AND SCREENING

(Sec. 267 of the bill)

Under section 1905(a)(4)(B) of the Social Security Act, States are required to provide diagnostic and screening services for all medicaid eligibles under 21. The committee has been advised that the Department of Health, Education, and Welfare has delayed issuance of regulations required to implement the above section because of the great cost which full implementation and application of the screening requirement would entail for both the Federal and State Governments.

The committee has included an amendment under which young children eligible for medicaid may be given priority in the provision of periodic diagnosis and screening. The Secretary would be authorized to establish, through regulations, orderly priorities for implementation of section 1905(a)(4)(B), giving initial priority in the provision of early and periodic diagnosis, screening and treatment to young children where States are unable to provide these services to their entire eligible population under 21.

The committee believes that the establishment of priorities will permit orderly and graded implementation of the requirement in all States.

The amendment is effective upon enactment.

MEDICAID COVERAGE OF MENTALLY-ILL CHILDREN

(Sec. 268 of the bill)

Under present law, medicaid payments for the mentally-ill in public mental institutions are generally limited to persons age 65 or over.

The committee amendment would authorize Federal matching under medicaid to also include eligible children, age 21 or under, receiving active care and treatment in an accredited institution for mental diseases. The definitions of active care and treatment and accredited mental institutions are those applicable to psychiatric institutional care under the medicare program. An appropriate "maintenance of effort" provision is included to assure that the new Federal dollars are utilized to improve and expand treatment of mentally-ill children.

The committee believes that the nation cannot make a more compassionate or better investment in medicaid than this effort to restore mentally-ill children to a point where they may very well be capable of rejoining and contributing to society as active and constructive citizens.

The effective date of the amendment is July 1, 1971.

CONSULTANTS FOR EXTENDED CARE FACILITIES

(Sec. 270 of the bill)

Among the conditions of participation for extended care facilities in the medicare program is the requirement that these facilities retain consultants in specialty areas such as the maintenance of medical records and the formulation of policies governing the provision of dietary and social services. Reimbursement is made to each facility only for that portion of the costs of the consultants' services representing services provided to medicare patients. For example, if 20 percent of the patient days in an extended care facility are medicare and the remaining 80 percent are medicaid patient days, the facility can recover only 20 percent of the costs of the consultants' services from the medicare program. The remaining 80 percent of the cost must come from the fixed per diem payment made by the State for medicaid patients.

The committee is aware that in many parts of the country consultants in these particular specialty areas are in short supply, competition for their services is intense, and the cost of retaining them on a per diem basis is often prohibitive for many extended care facilities. In some cases, the difficulty encountered by an extended care facility in retaining and paying for a consultant is compounded by the fact that a large number of the facility's patients are on medicaid. Often the State has provided similar consultative services for these medicaid patients, and no additional medicaid allowance can be made for the outside consultants employed to meet the medicare conditions of participation.

Under the committee bill those State agencies that are able and willing to provide these specialized consultative services for medicare patients in an extended care facility which requests them, would be authorized to do so, subject to approval by the Secretary. The provision of consultative services by the State agency on this basis would satisfy the medicare requirements relating to the use of consultants in the appropriate specialty areas. Payment by medicare would be made directly to the State agency for the costs incurred in rendering the consultative services. The State agency would be authorized to limit the availability of these services, consistent with its own assessment of available resources and needs.

This approach is in reality an extension of present responsibilities, since State agencies have had a consultative as well as a certifying role in medicare.

The amendment should result in lower costs to the medicare program as the consultants would be salaried employees of the State. It should also lead to more effective use of scarce personnel. Finally, determination of compliance by a facility with the required consultative services would be substantially simplified through verification at a single source—the State agency—rather than with a multiplicity of individual and scattered consultants.

The amendment is effective upon enactment.

TERMINATION OF NURSING HOME ADMINISTRATOR'S ADVISORY COUNCIL, DECEMBER 31, 1970

(Sec. 271 of the bill)

The 1967 Social Security Amendments required State licensure of nursing home administrators. The statute also established the National Advisory Council on Nursing Home Administration in order to study, develop, and advise the Secretary and the States concerning matters relating to the qualifications, training, and other areas related to a proper program of licensure. The Council was scheduled to terminate on December 31, 1971.

The committee has noted, however, that the Council has essentially completed its work and has passed a resolution to that effect. Therefore, the committee included an amendment providing for termination of the National Advisory Council on Nursing Home Administration as of December 31, 1970. It is expected that the existing Medical Assistance Advisory Council would assume responsibility for any continuing need for advice and assistance with respect to licensing of nursing home administrators.

MAINTENANCE OF EFFORT—MEDICAID

(Sec. 272 of the bill)

Pursuant to section 1902(d) of the Medicaid statute a State cannot reduce its expenditures for the State share of medicaid from one year to the next. Failure to comply with this requirement means ineligibility for Federal medicaid matching.

The committee has been concerned about the effect of section 1902(d) on States which may be faced with fiscal crises.

The State of Missouri has a particularly immediate and urgent fiscal problem and is unable to meet the 1902(d) requirements.

Many needy people would be denied necessary care in Missouri if its medicaid plan is formally found out of compliance with section 1902(d). Therefore, the committee amendment would exempt the State of Missouri from the application of section 1902(d)(1) retroactive to July 1, 1970.

Further, the committee believes that the maintenance of effort provision in medicaid now functions as a barrier to orderly development and operation of State programs, and that the States are best able to determine the changing need of their people. For these reasons the committee has provided for repeal of section 1902(d) upon enactment.

PENALTIES FOR FRAUDULENT ACTS AND FALSE REPORTING UNDER MEDICARE AND MEDICAID

(Sec. 273 of the bill)

Under present law, a false statement or representation of a material fact in any application for payment under social security programs is defined as a misdemeanor and carries a penalty of up to one year of imprisonment, a fine of \$1,000, or both.

The committee believes that a specific provision defining acts subject to penalty under the medicare and medicaid programs should be included to provide penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the medicare and medicaid programs. Thus, under the committee bill, the criminal penalty provision would include such practices as the soliciting, offering, or accepting of kickbacks or bribes, including the rebating of a portion of a fee or charge for a patient referral, involving providers of health care services. (Another amendment in title VI of this bill revives the Federal income tax statutes to deny a tax deduction with respect to such payments.) Under the bill, the penalty for such acts, as well as false statements or representations of material facts in any application for payment under the medicare and medicaid programs, would be a fine of \$10,000, one year of imprisonment, or both.

Continuing investigation and review of reports by the committee have indicated that false statements may have been made by individuals and institutions with respect to health and safety conditions and operating conditions in health care facilities in order to secure approval for participation in the medicare and medicaid programs.

While the numbers of different individuals and institutions involved in such fraud may not be large in relation to the number participating in the program, the committee believes that a specific penalty for such acts should be provided to deter the making or inducing of such statements. Consequently, the committee bill includes a specific provision under title XVIII and title XIX of the Social Security Act whereby anyone who knowingly and willfully makes, or induces or seeks to induce, the making of a false statement of material fact with respect to the conditions and operation of a health care facility or agency in order to secure certification or approval to participate in the medicare and medicaid programs will be subject to imprisonment for up to 6 months, a fine not to exceed \$2,000, or both.

The amendment is effective upon enactment.

PUBLIC DISCLOSURE OF INFORMATION CONCERNING AN INSTITUTION'S DEFICIENCIES

(Sec. 274 of the bill)

At present, information as to whether a hospital or extended care facility participating in the medicare program fully meets the statutory and regulatory requirements relating to conditions for participation, or whether it has significant deficiencies, is generally available only to the facility involved, appropriate State agencies, and the Administration. Physicians and the public in general are currently unaware as to which institutions among those participating in the Medicare program have significant deficiencies and which are making serious efforts to overcome those deficiencies. The committee believes that in the absence of public knowledge about the nature and extent of deficiencies of individual facilities, it is exceedingly difficult for physicians and the public to effectively direct their concern about shortcomings to the deficient facilities and to bring pressures for improvement to bear on those facilities.

The committee believes that easy public access to timely information about deficiencies (such as in areas of staffing, sanitation, fire and other safety requirements) would help significantly to encourage facilities to correct their deficiencies and, at the same time, enable physicians and patients to make sound judgments about their own use of available facilities in the community. The committee bill, therefore, requires the Secretary of Health, Education, and Welfare to make information on the significant deficiencies of individual providers a matter of public record readily available on request at all social security district offices and centrally at Social Security Administration headquarters. The Secretary would make this information available only after the provider has been fully informed about the significant deficiencies that have been identified and has been given a reasonable amount of time (not to exceed 90 days) to correct the deficiencies. It is expected that the Secretary will take the necessary administrative steps to assure that the information made available is updated periodically as appropriate.

The amendment is effective upon enactment.

AUTHORITY FOR ESTABLISHING LIENS TO PERMIT RECOVERY OF OVERPAYMENTS

(Sec. 275 of the bill)

Under present law, where a provider of services has been overpaid, the Department of Health, Education, and Welfare is authorized to withhold future payments which are otherwise due to the provider in order to recoup the amount of the overpayment. Where no further payments are due because, for example, the provider has withdrawn from the program, the Department has experienced difficulty in attempting to recover the amount overpaid.

The committee is concerned because, in dealing with the problem of recovery of overpayments to providers of services, it has found that an effective administrative remedy to protect the interests of the Government does not exist in certain cases. These cases involve (1) providers who have terminated their participation in the program, and who refuse to refund any money to meet the debt incurred by an overpayment; and (2) providers who continue to participate in the Medicare program, but who have very low utilization by Medicare beneficiaries with the result that little or no Medicare payments are due the provider.

If a provider refuses to refund, the Department's recourse in such a situation is to send demand letters at prescribed intervals and, if this action does not result in a refund, to refer the case to the General Accounting Office for collection. If GAO is unsuccessful in obtaining refund, the case may be referred to the Department of Justice for legal action. The committee is concerned, however, that until the case is referred to the Department of Justice, no effective administrative action can be taken to prevent dissipation or diversion of assets by the provider while recovery efforts are being conducted. During this time, the provider has had Government funds at his disposal on which he does not have to pay interest. Furthermore, he has time to dispose of his assets so that if legal action is ever undertaken to collect the debt, there may not be any assets available to meet the obligation.

If, however, a lien in favor of the Government in the amount of the overpayment was placed upon the property of the provider, the assets of the provider would be conserved while the Government is taking the necessary collection action.

The committee bill, therefore, would provide authority, where a determination of an overpayment has been made, or the overpayment issue is being contested, for establishing a lien in favor of the U.S. Government in the amount of the overpayment upon all property belonging to the provider overpaid. Where a lien is filed the provider would have the right to challenge the overpayment determination or issue by requesting a hearing by the Secretary of Health, Education and Welfare and where requested such hearing should be promptly provided. Liens would be filed locally. In addition, the provider would have a right to judicial review of the Secretary's final decision to apply a lien after a hearing, if he is dissatisfied with the decision.

The amendment would become effective upon enactment.

INCLUSION OF AMERICAN SAMOA AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS UNDER TITLE V

(Sec. 276 of the bill)

American Samoa and the Trust Territory of the Pacific Islands are currently excluded from receiving Federal funds under the provisions of the Crippled Children and Maternal and Child Health Programs (title V).

All other territories and possessions of the United States are presently eligible for the benefits of these programs. The provision of public health services to mothers and children with crippling disease is one of the areas of greatest weakness in public health programs in Micronesia, and this is reflected in a high infant mortality rate.

The committee bill would include American Samoa and the Trust Territory of the Pacific Islands as eligible to receive an allotment of funds under title V of the Social Security Act.

The amendment is effective with respect to fiscal years beginning on and after July 1, 1971.

RELATIONSHIP BETWEEN MEDICAID AND COMPREHENSIVE HEALTH CARE PROGRAMS

(Sec. 277 of the bill)

Present law provides that under title XIX all eligible recipients should receive the same scope of services; that those services should be available throughout the State and that recipients should have freedom of choice with regard to where they receive their care.

Section 1902(a) (23) also provides that recipients be allowed to obtain medical care through organizations which provide such services (or arrange for their availability) on a prepayment basis, if the recipient so chose.

State agencies often cannot make pre-payment arrangements which might result in more efficient and economical delivery of health serv-

ices, because the prospective arrangements might violate title XIX in that some recipients might receive a broader scope of benefits than others. This is so because the possibility for making such arrangements may only exist in certain areas of a State.

The committee bill would amend section 1902(a)(23) to permit a State to make arrangements for the delivery of health services on a pre-paid basis in an area, including arrangements with neighborhood health centers, where such services are available and to the extent they are provided, without a requirement that such arrangement necessarily be provided all Medicaid eligibles in the State with the approval of the Secretary.

The amendment is effective upon enactment.

REFUNDING OF EXCESS MEDICARE PREMIUMS

(Sec. 278 of the bill)

Under present law, where part B entitlement terminates due to the death of the enrollee, refund of any excess premiums is made, upon claim, to the legal representative of the enrollee's estate. If there is no legal representative and it is reasonably certain that none will be appointed, refund may be made, only upon claim, to a relative of the deceased on behalf of the estate.

It has come to the committee's attention that early in the program it was recognized that excess part B premiums paid by a deceased enrollee could be best disposed of, in those cases where there is no legal representative of the deceased's estate, by adding them to benefits subsequently payable on the same Medicare claims number, or to those relatives who would (except for age or dependency requirements) be eligible on the same record. However, the Office of General Counsel has advised that this could not be done in the absence of necessary authority in the law. Consequently, the much more cumbersome claims procedure has had to be used. Where there is no claim for the excess premium payments, no refund is made.

A similar problem is likely to exist with respect to premiums paid in advance under the provision of the bill which would provide, at a cost of \$27 per month per enrollee, hospital insurance coverage for people who are age 65 and over and who are not eligible for such coverage under present law.

The committee bill, therefore, would provide authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums in the same manner as unpaid medical insurance benefits are treated.

DEFINITION OF PHYSICIAN UNDER MEDICAID

(Sec. 279 of the bill)

The committee has amended section 1905(a)(5) of Medicaid so as to clarify the definition of a physician as being a duly licensed doctor of medicine or osteopathy.

Services of other types of health care practitioners are authorized in subsequent provisions of Section 1905(a).

REIMBURSEMENT APPEALS BY PROVIDERS OF SERVICES

(Sec. 281 of the bill)

Under present law a fiscal intermediary determines the amount of reasonable cost to be paid to a provider of services. There is no specific legislative provision for an appeal by the provider of the intermediary's final reasonable cost determinations. Although the Social Security Administration has instituted certain administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items, the committee believes that it is desirable to prescribe in law a specific appeals procedure for disputed final settlements applying to reasonable cost determinations. This procedure does not apply to questions of coverage or disputes involving individual beneficiary claims.

The committee bill, therefore, provides for the establishment of the Provider Reimbursement Appeals Board. The Board will be composed of 5 members, properly qualified in the Medicare field, appointed by the Secretary of Health, Education, and Welfare. At least one member of the Board will be a certified public accountant. The Secretary will select 2 of the members from qualified and acceptable nominees of the providers.

Any provider of services (or groups of such providers) which has filed timely cost reports may appeal an adverse final decision of the fiscal intermediary to the Board where the amount at issue aggregates \$10,000 or more. In addition, any provider which has not received a final cost determination from the fiscal intermediary within 90 days of filing its annual cost report, if such report is substantially in proper order, or within 90 days from an acceptable supplemental filing, where the initial filing was deficient, may appeal to the Board where the amount at issue is \$10,000 or more.

The provider shall have the right to reasonable notice as to the time and place of hearing and reasonable opportunity to appear at the hearing. It may be represented by counsel and introduce reasonable and pertinent evidence to supplement or contradict the evidence considered by the fiscal intermediary. Reasonable opportunity to examine and cross-examine witnesses shall be provided. All decisions by the Board shall be based upon the record made at such hearing which may include any evidence submitted by the Department. Such evidence shall include the evidence or record considered by the intermediary. Based upon examination of all of the evidence, such Board may find in whole or in part for the provider or the Government (including a finding based upon the evidence before it that the provider or Government owes sums in addition to the amount raised in the appeal).

The decision of the Provider Reimbursement Appeals Board shall be final, subject to review and affirmation by the Secretary. The Secretary shall have 60 days to review the decision. If the Board's decision is unfavorable to the provider and is not affirmed by the Secretary

or if a decision favorable to the provider is reversed by the Secretary within the 60-day period, the provider shall have the right to review by the United States District Court in which it is located or in the United States District Court for the District of Columbia, as an aggrieved party under the Administrative Procedure Act, notwithstanding any other provision in section 205 of this title.

The amendment would become effective with respect to accounting periods ending after June 30, 1971.

STATUTE OF LIMITATIONS—WAIVER OF RECOVERY OF INCORRECT PAYMENTS UNDER THE MEDICARE PROGRAM

(Sec. 282 of the bill)

Under present law, the Secretary is required to recover overpayments made to or on behalf of an individual where it is determined that services for which payment has been made were not covered under medicare. Further, present law provides that overpayments made to providers or other persons for services furnished an individual, which cannot be recovered from the overpaid provider of services or other person, may be recovered by decreasing subsequent payments to which an individual is entitled under title II of the Act.

Present law also provides that adjustment or recovery of an incorrect payment will not be made with respect to an individual who is without fault and where such an adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience. However, there are no similar provisions specifically authorizing the application of waiver with respect to providers of services and other overpaid persons. While the Administration has developed guidelines to specify the situations where a provider of services or other person should not be held responsible for repayment of incorrect amounts, the committee has added provisions to apply where it seems inequitable to recover from a provider or the individual.

The committee is particularly concerned about overpayments discovered long after the payment was made. It, has therefore, provided that, after 3 years have expired, there be a presumption, in the absence of evidence to the contrary, that the provider or other person shall be deemed to be without fault with respect to an overpayment and that under such circumstances no collection should be made.

The committee recognizes that in making decisions as to the medical necessity for services and the level of care which may be provided an individual in an institutional setting, often the provider of services or other person has placed reasonable reliance upon the physician's decision as to the need for the services provided or for the individual's admission to a medical facility. Further, the committee recognizes that the individual who receives the services may have little basis for evaluating the appropriateness of the level of care provided him and that it can be inequitable in such situations to find that he is at fault with respect to any incorrect payments that may be made by medicare for the services he received.

The amendment also requires that providers under their participation agreements (or physicians or other persons where they have accepted assignments) where collection of an overpayment is made from the provider or others, be prohibited, after 3 years, from charging beneficiaries for services found by the Secretary to be medically unnecessary or custodial in nature, in the absence of fault on the part of the individual who received the services.

Additionally, the Secretary would be authorized to deny claims for reimbursement made after lapse of a reasonable period of time specified by him in regulation, of not less than 1 year nor more than 3 years.

The amendment is effective upon enactment.

EXTENSION OF 75 PERCENT FEDERAL MATCHING FOR MEDICAL PERSONNEL UNDER CONTRACT

(Sec. 283 of the bill)

Present law permits Federal financial participation at the 75-percent rate for the compensation of skilled professional medical personnel and staff directly supporting such personnel of the State agency or of any public agency involved in the administration of the title XIX program at the State or local level. Such personnel and staff include physicians; members of other health professions such as dentists, medical and psychiatric social workers, nurses, and pharmacists; other specialized personnel, such as research specialists and experts on medical costs. States are compensated at a 50-percent level for general administration of the title XIX program.

The committee has extended the 75-percent matching rate to include additional skilled medical personnel and direct supporting staff other than those of the State agency itself. States would thus be able, by contract arrangements, to use professional medical personnel for independent professional and medical audits required with respect to patients in skilled nursing homes, mental institutions, and intermediate care facilities whose use might otherwise not be economical.

The amendment is effective upon enactment.

4. ADDITIONAL MATTERS OF CONCERN TO THE COMMITTEE

UNIFORM MEDICARE REIMBURSEMENT

Under present medicare regulations, providers have the option to be reimbursed under the Departmental Method or Combination Method of apportionment of costs between medicare and others who pay for care. (Under the option a change from one method to another requires a timely written request filed ahead of time by the provider and approval by its intermediary.) To determine medicare reimbursement under the Departmental Method, the ratio of beneficiary charges to total patient charges for the services of each department is applied to the cost of the department. Under the Combination Method, the cost of routine services for medicare beneficiaries is determined on an average cost per diem basis and to this is added the cost of ancillary services determined by apportioning the total cost of ancillary services on the basis of the ratio of medicare beneficiary charges for ancillary services to total patient charges for such services.

Both the Comptroller-General of the United States and the HEW Audit Agency have recommended that the use of the combination method should be eliminated because certain pediatric and obstetrical costs are included in the total ancillary service costs against which the medicare portion of charges are applied to arrive at program reimbursement. If charges are below cost for the pediatric and obstetrical services that are involved and charges are above cost for medicare ancillary services as a whole, as appears to be the case in many hospitals, some of the loss on these nonmedicare services is shifted to medicare. There are no rational grounds for preserving the unintended reimbursement of such costs where it is feasible to avoid such payment. Furthermore, the statute requires that medicare pay only for the actual costs associated with the elderly.

The committee is also aware that the Combination Method of apportionment while less accurate than the Departmental Method of apportionment has been retained for medicare reimbursement to avoid imposing the greater complexity of the Departmental Method on institutions incapable of handling it. The statute permits the determination of an institution's reimbursable costs using various methods and through the use of estimates, and the choice of methods requires a balancing of accuracy as to the reimbursable amount against the cost and difficulty of obtaining it. At the same time, the committee has also noted that under present regulations and cost reporting procedures (which allow large as well as small institutions to use the combination method at their option) much of the cost finding required by medicare is the same for providers using either the Departmental Method or the Combination Method, and many small providers find this cost finding requirement quite difficult to meet. Moreover, when the original medicare reimbursement regulations were developed, it was believed by the Department of HEW that even some relatively large hospitals would have difficulty completing the required cost finding and would also be unable to apportion costs under the Departmental Method because of poor recordkeeping practices, and this initial provision for simplifying reimbursement even for the largest institutions seems reasonable for the past.

It is recognized that medicare cost finding and cost reporting requirements have contributed to an upgrading in recordkeeping and accounting systems and it does not seem unreasonable now to expect all larger institutions which generally receive larger medicare payments to use the more accurate Departmental Method of apportionment of costs between medicare and other payers. On the other hand, the committee is concerned that for smaller providers program cost finding requirements should be simplified wherever possible and wherever equitable.

Therefore, the committee and the Department concur that the Department should simplify its cost finding and cost reporting requirements for smaller institutions (e.g. those having less than 100 beds) and require the use of the Combination Method by those institutions without an option to use the Departmental Method. At the same time larger institutions (e.g. those with 100 beds or more) should be required to carry out cost finding under more sophisticated methods and to apportion costs under the more accurate Departmental Method.

By requiring simplified cost finding and the Combination Method for smaller institutions and the Departmental Method for larger institutions the program would: eliminate the provider option which gives a provider an advantage in reimbursement based on informed selection of method (not necessarily on any justifiable merit); eliminate the need for providers to try out more than one method to see which is more favorable; relate the degree of cost finding and cost determinations to the relative administrative expertise of providers (there is a correlation between accounting systems and expertise and institution size); result in better cost reimbursement determinations for the larger institutions which receive the greater part of Medicare payments; and permit better cost analyses for making program payment determinations because all providers of a given size would use the same method of cost finding and be reimbursed under the same method of apportionment. Moreover, it is expected that implementing these requirements would reduce the recordkeeping and auditing costs of both the institutions and the program.

The Department has stated that it will move ahead as expeditiously as possible, after appropriate consultation, to develop and implement through regulations, forms, and instructions the new cost finding and cost reporting requirements to be applied after due notice. Such requirements are expected to apply to institutional fiscal years beginning on or after July 1, 1971. It is reasonable to continue to explore possible revisions in cost finding and cost apportionment to always seek the best balance of accuracy and equity.

MEDICARE CARRIERS AND INTERMEDIARIES

Carriers and intermediaries are the private insurance companies and Blue Cross and Blue Shield plans who serve as agents of the Government in administering medicare. In keeping with its continuing concern that medicare's administrative performance be substantially improved, the committee reiterates the original Congressional intent that inefficient and uneconomical medicare carriers and intermediaries be promptly terminated and replaced as soon as possible by more capable organizations including, if no other alternative is suitable, the Department itself. In general, this intent has not been complied with. It is fully expected that it will be followed from here on even if, in the short-run, additional start-up and related costs are necessarily incurred.

V. CATASTROPHIC HEALTH INSURANCE PROGRAM

Catastrophic Health Insurance Program

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V. CATASTROPHIC HEALTH INSURANCE PROGRAM

The Committee on Finance is concerned about the devastating effect which a catastrophic illness can have on families unfortunate enough to be affected by such an illness. Over the past decades science and medicine have taken great strides in their ability to sustain and prolong life. Patients with kidney failure, which until recently would have been rapidly fatal, can now be maintained in relative good health for many years with the aid of dialysis and transplantation. Patients with spinal cord injuries and severe strokes can now often be restored to a level of functioning which would have been impossible years ago. Modern burn treatment centers can keep victims of severe burns alive and can offer the victim restorative surgery which can in many instances erase the after effects of such burns.

These are but a few examples of the impact which recent progress in science and medicine has had. This progress, however, has had another impact. These catastrophic illnesses and injuries which heretofore would have been rapidly fatal and hence not too expensive financially, now have an enormous impact on a family's finances. The newly developed methods of treating catastrophic illnesses and injuries involve long periods of hospitalization, often in special intensive care units, and the use of complex and highly expensive machines and devices. The net cost of a catastrophic illness or injury can be and usually is staggering. Hospital and medical expenses of many thousands of dollars can rapidly deplete the resources of nearly any family in America. These families are then faced not only with the devastating effect of the illness itself, but also with the necessity of accepting charity or welfare. Catastrophic illnesses do not strike often, but when they do the effects are disastrous—particularly in the context of soaring health care costs.

The Committee on Finance believes that Government and social insurance programs should be able to respond to the progress made in medical science. Medicine and science are now often able to mitigate the physical effects of a catastrophic illness or injury, and the committee believes that government, through our established social insurance mechanism should act to mitigate the financial effects of such catastrophes.

The committee has adopted an amendment which would establish a Catastrophic Health Insurance Program.

The program would be designed to complement private health insurance which has played the major role in insuring against basic health expenses. About 80 percent of people under age 65 have insurance against hospitalization expenses, but these policies all have a limit on hospital days which they will cover. The most common policies cover 60 days of care. Similarly, existing private policies designed to cover medical expenses have upper limits of coverage. Private major medical insurance plans are available, but are held by only

20 to 30 percent of the population. In addition, even the major medical plans have maximum benefits per spell of illness, usually ranging from \$5,000 to \$20,000.

The committee's Catastrophic Health Insurance Program would be structured to take maximum advantage of the experience gained by medicare. The program would use medicare's established administrative mechanism wherever possible, and would incorporate all of medicare's cost and utilization controls.

ELIGIBILITY

The committee amendment establishes a new Catastrophic Health Insurance Program (CHIP) as part of the Social Security Act financed by payroll contributions from employees, employers and the self-employed. Under the committee's provision all persons under age 65 who are fully or currently insured under the social security program, their spouses and dependent children would be eligible for CHIP protection. All persons under age 65 who are entitled to retirement, survivors, or disability benefits under social security as well as their spouses and dependent children would also be eligible for CHIP. This constitutes about 95 percent of all persons under age 65.

Persons over 65 would not be covered as they are protected under the medicare program which, in spite of its limitation on hospital and extended-care days, is a program with a benefit structure adequate to meet the significant health care needs of all but a very small minority of aged beneficiaries. The largest noncovered groups under age 65 are Federal employees, employees covered by the Railroad Retirement Act, and State and local governmental employees who are eligible for social security but not covered due to the lack of an agreement with the State. (There are a small number of people who are still not covered by social security or other retirement programs; the majority of these are domestic or agricultural workers who have not met the necessary social security coverage requirements.)

Federal employees are, however, eligible for both basic and major medical catastrophic health insurance protection under the Federal Employees Health Benefits Act, with the Federal Government paying 40 percent of the costs of such coverage. To assure equitable treatment of those Federal employees who also are eligible for social security, a special provision of the committee bill would require the Federal Employees Health Benefits program to make available to Federal employees who have sufficient social security coverage to be eligible under CHIP, a plan which supplements CHIP coverage; if such a plan is not made available to Federal employees, no CHIP payments will be available for services otherwise payable under the FEHB plan.

BUY-IN FOR STATE AND LOCAL EMPLOYEES

Under the committee bill, State and local employees who are not covered by social security could receive coverage under CHIP if the State and local governments exercise an option to buy into the program to cover them on a group basis. When purchasing this protection, States

would ordinarily be expected to include all employees and eligible annuitants under a single agreement with the Secretary. A determination by the State as to whether an individual is an annuitant or member of a retirement system or is otherwise eligible to have such coverage purchased on his behalf would, for purposes of the agreement to provide CHIP protection, be final and binding upon the Secretary. Each State which enters into an agreement with the Secretary of Health, Education, and Welfare to purchase CHIP protection will be required to reimburse the Federal Catastrophic Health Insurance Trust Fund for the payments made from the fund for the services furnished to those persons covered under CHIP through the State's agreement with the Secretary, plus the administrative expenses incurred by the Department of Health, Education, and Welfare in carrying out the agreement. Payments will be made from the fund to providers of services for covered services furnished to these persons on the same basis as for other persons entitled to benefits under CHIP. Conditions are also specified under which the Secretary or the State could, after due notice, terminate the agreement.

BENEFITS

The benefits that would be provided under CHIP would be the same as those currently provided under parts A and B of medicare, except that there would be no upper limitations on hospital days, extended care facility days, or home health visits. Present medicare coverage under part A includes 90 days of hospital care and 60 days of post-hospital extended care in a benefit period, plus an additional lifetime reserve of 60 hospital days; and 100 home health visits during the year following discharge from a hospital or extended care facility. Part B coverage includes physicians' services, 100 home health visits annually, outpatient physical therapy services, laboratory and X-ray services and other medical and health items and services such as durable medical equipment.

The major benefits excluded from medicare, and consequently excluded from this proposal, are nursing home care, prescription drugs, hearing aids, eyeglasses, false teeth and dental care. Medicare's limitations on inpatient care in psychiatric hospitals, which limit payment to active treatment subject to a 190 day lifetime maximum, and the program's annual limitation on outpatient services in connection with mental, psychoneurotic and personality disorders are also retained. An additional exclusion would be for items or services which the Secretary of Health, Education, and Welfare rules to be experimental in nature.

DEDUCTIBLES AND COINSURANCE

The committee believes that in keeping with the intent of this program to protect against health costs so severe that they usually have a catastrophic impact on a family's finances, a deductible of substantial size should be required. The committee's proposal has two entirely separate deductibles which would parallel the inpatient hospital deductible under part A and the \$50 deductible under part B of medicare.

The separate deductibles are intended to enhance the mesh of the program with private insurance coverage. In order to receive both hospital and medical benefits, both deductibles must be met. If a person were to meet the hospital deductible alone, he would become eligible only for the hospital and extended care benefits. Similarly, if a family were to meet the \$2,000 medical deductible, they would become eligible only for the medical benefits.

HOSPITAL DEDUCTIBLE AND COINSURANCE

There would be a hospital deductible of 60 days hospitalization per year per individual.

After an individual has been hospitalized for a total of 60 days in one year, he would become eligible for payments toward hospital expenses associated with continued hospitalization. The program would thus begin payment with the 61st day of his hospitalization in that year. Only those posthospital extended care services which he receives subsequent to having met the 60-day deductible would be eligible for payment.

After the hospital deductible has been met, the program would pay hospitals substantially as they are presently paid under medicare, with the individual being responsible for a coinsurance amount equal to one-fourth of the medicare inpatient hospital deductible applicable at that time. Extended care services which are eligible for payment would be subject to a daily coinsurance amount equal to one-eighth of the medicare inpatient hospital deductible. In January 1971, this coinsurance will amount to \$15 a day for inpatient hospital services and \$7.50 a day for extended care services.) Thus the coinsurance could rise yearly in proportion to any increase in hospital costs.

MEDICAL DEDUCTIBLE AND COINSURANCE

There would be a supplemental medical deductible initially established at \$2,000 per year per family. The Secretary of Health, Education, and Welfare would, between July 1 and October 1 of each year (beginning in 1972), determine and announce the amount of the supplemental medical deductible for the following year.

The deductible would be the greater of \$2,000 or \$2,000 multiplied by the ratio of the physicians' services component of the Consumer Price Index for June of that year to the level of that component for December 1971. Thus, the deductible could rise yearly in proportion to any increase in the price of physicians' services.

After a family has incurred expenses of \$2,000 for physicians' bills, home health visits, physical therapy services, laboratory, and X-ray services and other covered medical and health services the family would become eligible for payment under the program toward these expenses. For purposes of determining the deductible, a family would be defined as a husband and wife and all minor and dependent children.

After the medical deductible had been met, the program would pay for 80 percent of eligible medical expenses, with the patient being responsible for coinsurance of 20 percent.

DEDUCTIBLE CARRYOVER

As in part B of medicare, the plan would have a deductible carry-over feature—applicable to both the dollar deductible and the hospital-day deductible—under which expenses incurred (or hospital days used) but not reimbursed during the last calendar quarter of a year would also count toward the satisfaction of the deductibles for the ensuing year. For example, an individual admitted to a hospital with a cardiac condition on December 10, 1972, and continuously hospitalized through February 19, 1973, would not, in the absence of the carry-over provision, meet the hospital-day deductible unless he were to be hospitalized for at least another 10 days in 1973. With a carryover provision, however, the individual described above would meet the hospital deductible on January 30, 1973. Similarly, if a family's first eligible medical expenses in 1972 amount to \$1,200 and were incurred during the months of November and December, and an additional \$3,000 in eligible medical expenses are incurred in 1973, the family would, in the absence of a carryover provision, be eligible for payment towards only \$1,000 of their expenses in 1973. With a carryover provision, however, the family described above would be eligible for payment toward \$2,200 of their expenses in 1973.

ADMINISTRATION

Payments made to patients, providers, and practitioners under this program would be subject to the same reimbursement, quality, health and safety standards, and utilization controls as exist in the medicare program. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. However, the committee expects that appropriate modifications will be made to take into account the special features of this program, including a modification to exclude "bad debts" from those costs eligible in computing reasonable cost payments to institutions.

The utilization of services would be subject to review by present utilization review committees established in hospitals and extended care facilities and by the professional standards review organizations established under another committee amendment. The committee believes that all of the above controls should be applied to reimbursement of expenses for services rendered under the proposed catastrophic illness insurance program. In addition, the Office of the Inspector General for Health Administration established under another committee amendment would be expected to closely monitor the administration of the program and can be expected to provide valuable information with respect to increasing the efficiency of the program.

The proposal contemplates using the same administrative mechanisms used for the administration of medicare including, where appropriate, medicare's carriers and intermediaries. Using the same administrative mechanisms as medicare will greatly facilitate the operation of this program. The proposal also would encompass use of medicare's statutory quality standards, in that the same conditions of participation which apply to institutions participating in medicare would apply to those institutions participating in CHIP. These standards

serve to upgrade the quality of medical care and their application under this program should have a similar salutary effect.

The Social Security Administration, utilizing its network of district offices, would determine the insured status of individuals and relationships within families which are necessary to establish entitlement to CHIP benefits. The determination of whether the deductible expenses had been met would also be handled by the Social Security Administration in cooperation with carriers and intermediaries. The proposed administrative plan envisions establishing a \$2,000 minimum expense amount before individual bills would be accepted. This would protect the administrative agencies from being inundated with paperwork.

FINANCING

The first year's cost of the program is estimated at \$2.5 billion on an incurred basis and \$2.2 billion on a cash basis. The committee provision would finance the program on a \$9,000 wage base with the following contribution schedule: 1972-74, 0.3 of one percent of taxable payroll on employees and 0.3 on employers; 1975-79, 0.35; 1980 and after, 0.4. Rates for the self-employed would also be 0.3, 0.35, and 0.4 respectively.

The contributions would be placed in a separate Federal Catastrophic Health Insurance Trust Fund from which benefits and administrative expenses related to this program would be paid. The complete separation of catastrophic health insurance financing and benefit payments is intended to assure that the catastrophic health insurance program will in no way impinge upon the financial soundness of the retirement, survivors, or disability insurance trust funds or medicare's hospital and supplementary medical insurance trust funds. Such separation will also focus public and congressional attention closely on the cost and the adequacy of the financing of the program.

To provide an operating fund at the beginning of the program (in recognition of the lag in time between the date on which the taxes are payable and their collection), and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis without interest) during the first 3 calendar years of the program. The amount which could be drawn in any such calendar year could not exceed the estimated amount of 6 months of benefit payments during that year.

RELATIONSHIP WITH MEDICAID

The catastrophic illness insurance program would be supplemental to the medicaid program with regard to public assistance recipients and the medically indigent in the same way in which it will be supplemental to private insurance for other citizens. Thus, medicaid will continue to be the State-Federal program that is intended to cover the basic health needs of categorical assistance recipients and the medically indigent. The benefit structure of medicaid varies from State to State, but in general it is a basic rather than a catastrophic benefit package.

In addition, medicaid will continue to play a substantial role in financing the cost of nursing home care, which represents a cata-

strophic cost to many people, especially the aged. The catastrophic health insurance program will, of course, lessen the burden on the medicaid program to some degree, since those covered by medicaid who are eligible would have a large proportion of their catastrophic expenses covered by this program, leaving only the deductible and coinsurance amounts for the medicaid program to pay. This factor will not only enable the States to contain the costs of their programs, but may also encourage them to improve coverage of basic services.

CONCLUSION

The committee estimates that more than one million families of the approximately 49 million families in the United States annually incur medical expenses which will qualify them to receive benefits under the program. Of course, nearly all American families will receive the benefit of insurance protection against the costs of catastrophic illnesses. The program is not intended to meet the health costs which the population incurs for short-term hospitalization and acute illness. This program is intended to insure against those highly expensive illnesses or conditions which, although a potential threat to every family, actually strike only a relatively few. The committee believes that individuals should, during their working years, be able to obtain protection against the devastating and demoralizing effects of such costs.

These provisions and the taxes to pay for them would become effective January 1, 1972.

VI. FINANCING OF SOCIAL SECURITY TRUST FUNDS

Financing of Social Security Trust Funds

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VI. FINANCING OF SOCIAL SECURITY TRUST FUNDS

A. FINANCING PROVISIONS

Consistent with the policy of maintaining the social security program on a financially sound basis, which has been followed in the past, the bill would make provision for meeting the cost of the expanded program. At the present time, the social security cash benefits program is in close actuarial balance, while the hospital insurance program has a serious actuarial deficiency; that is, unless hospital insurance taxes are raised substantially, the hospital insurance trust fund will become exhausted in 1972. To meet the cost of the expanded cash benefits program and the new catastrophic illness insurance program and to bring the hospital insurance program into actuarial balance, the schedule of contribution rates would be revised and the contribution and benefit base—the maximum amount of annual earnings subject to contributions and used in computing benefits—would be increased.

INCREASE IN THE CONTRIBUTION AND BENEFIT BASE

The proposed increase in the contribution and benefit base from \$7,800 to \$9,000 in 1971 would not only provide higher benefits at higher earnings levels, but also would help to finance the changes made by the bill. An increase in the base results in a reduction in the overall cost of the social security program as a percent of taxable payroll. This occurs because the benefits provided are a higher percentage of earnings at the lower levels than at the higher levels, while the contribution rate is a flat percentage of earnings. When the base is increased, higher benefits are provided on the basis of the higher earnings that are taxed and credited, but the cost of providing these higher benefits is less than the additional income from the combined employee and employer contributions on earnings above the former maximum and up to the new maximum amount.

CHANGES IN THE CONTRIBUTION RATES

Under the schedule of contribution rates that the committee recommends (shown below), the contribution rate for the cash benefits part of the program scheduled for 1971-72 would be decreased from 4.6 percent each for employees and employers to 4.4 percent each. The rate for 1973-74 under present law would be decreased from 5 to 4.4 percent each. The rate for 1975-79 would be 5 percent, the same as under present law. The rate for 1980-85 would be 5.5 percent each, the same as it would be under the House bill. After 1985, the contribution rate would be 6.1 percent each [instead of 5 percent each as under present law].

For the self-employed, the rate scheduled for 1971-72 for cash benefits would be decreased from 6.9 to 6.6 percent. The rate for

1973-74 under present law would be decreased from 7 to 6.6 percent. After 1974, the self-employed contribution would increase to 7 percent, the same as the highest rate scheduled under present law and under the House bill.

The committee recommends a change in the contribution rate schedule for the hospital insurance program. The contribution rate would be increased from 0.6 percent each for employees, employers, and the self-employed to 0.8 percent in 1971-72, to 0.9 percent in 1973-74, to 1.0 percent in 1975-79, and to 1.1 percent for years after 1979. Under present law the rate is scheduled to increase gradually from the present 0.6 to 0.9 percent for 1987 and after, while under the House bill it would increase immediately to 1 percent in 1971 and thereafter.

The committee bill also provides for a contribution rate which would finance adequately the committee's provision for catastrophic illness insurance. The contribution rate for this protection would be 0.3 percent each for employees, employers, and the self-employed for 1972-74, after which the rate would increase to 0.35 percent in 1975-79, and to 0.4 percent for years after 1979.

CONTRIBUTION RATES UNDER PRESENT LAW AND H.R. 17550

[In percent]

Period	OASDI			HI			CI com- mittee bill	Total		
	Present law	House bill	Com- mittee bill	Present law	House bill	Com- mittee bill		Present law	House bill	Com- mittee bill
Employer—Employee, each										
1971-----	4.6	4.2	4.4	0.6	1	0.8	-----	5.2	5.2	5.2
1972-----	4.6	4.2	4.4	.6	1	.8	0.3	5.2	5.2	5.5
1973-74-----	5.0	4.2	4.4	.65	1	.9	.3	5.65	5.2	5.6
1975-----	5.0	5.0	5.0	.65	1	1.0	.35	5.65	6.0	6.35
1976-79-----	5.0	5.0	5.0	.7	1	1.0	.35	5.7	6.0	6.35
1980-85-----	5.0	5.5	5.5	.8	1	1.1	.4	5.8	6.5	7.0
1986-----	5.0	5.5	6.1	.8	1	1.1	.4	5.8	6.5	7.6
1987 and after----	5.0	5.5	6.1	.9	1	1.1	.4	5.9	6.5	7.6
Self-employed										
1971-----	6.9	6.3	6.6	0.6	1	0.8	-----	7.5	7.3	7.4
1972-----	6.9	6.3	6.6	.6	1	.8	0.3	7.5	7.3	7.7
1973-74-----	7.0	6.3	6.6	.65	1	.9	.3	7.65	7.3	7.8
1975-----	7.0	7.0	7.0	.65	1	1.0	.35	7.65	8.0	8.35
1976-79-----	7.0	7.0	7.0	.70	1	1.0	.35	7.70	8.0	8.35
1980-86-----	7.0	7.0	7.0	.80	1	1.1	.4	7.8	8.0	8.50
1987 and after----	7.0	7.0	7.0	.90	1	1.1	.4	7.9	8.0	8.50

MAXIMUM ANNUAL SOCIAL SECURITY TAXES UNDER PRESENT LAW, THE HOUSE BILL AND THE COMMITTEE BILL

Period	Employer-employee, each			Self-employed		
	Present law	House bill	Committee bill	Present law	House bill	Committee bill
1971-----	\$405.60	\$468.00	\$468.00	\$585.00	\$657.00	\$666.00
1972-----	405.60	468.00	495.00	585.00	657.00	693.00
1973-74-----	440.70	468.00	504.00	596.70	657.00	702.00
1975-----	440.70	540.00	571.50	596.70	720.00	751.50
1976-79-----	444.60	540.00	571.50	600.60	720.00	751.50
1980-85-----	452.40	540.00	630.00	608.40	720.00	765.00
1986-----	452.40	585.00	684.00	616.20	720.00	765.00
1987 and after-----	460.20	585.00	684.00	-----	-----	-----

CHANGE IN ALLOCATION TO THE DISABILITY INSURANCE TRUST FUND

The bill would revise the allocation of contribution income to the disability insurance trust fund. Under present law, 1.10 percent of taxable wages and 0.825 of 1 percent of self-employment income are allocated to the disability insurance trust fund. Under the committee bill, the allocation for 1971 would be reduced to 0.90 percent of taxable wages and 0.675 of 1 percent of self-employment income, and would remain at a level below the present law allocation until 1980. The allocations under present law, the House-passed bill, and the committee bill are shown on the following table:

[In percent]

Calendar year	Present law		House-approved bill		Committee bill	
	Taxable wages	Self-employment income	Taxable wages	Self-employment income	Taxable wages	Self-employment income
1971-----	1.10	0.825	0.90	0.6750	0.90	0.6750
1972-74-----	1.10	.825	.90	.6750	.95	.7125
1975-79-----	1.10	.825	1.05	.7875	1.05	.7350
1980-85-----	1.10	.825	1.15	.8625	1.35	.8600
1986 and after-----	1.10	.825	1.15	.8625	1.45	.8300

The revision in the allocation will adequately finance the disability provisions in the committee bill and reduce the expected growth in the disability insurance trust fund over the next several years. The committee believes that this growth is not necessary and that the allocation can be reduced below that specified in present law until 1980.

B. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

SUMMARY OF ACTUARIAL COST ESTIMATES

The old-age, survivors, and disability insurance system, as modified by the committee bill, has an estimated cost for benefit payments and administrative expenses that is closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by the committee bill shows an actuarial balance of -0.14 percent of taxable payroll under the intermediate-cost estimate. This seems an acceptable balance, especially considering that this estimate is based on conservative assumptions, that a range of variation is necessarily present in long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by the committee bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows an actuarial balance of -0.01 percent of taxable payroll under the provisions that would be in effect after enactment of the committee bill. This is, of course, close to exact actuarial balance. Accordingly, the disability insurance program, as it would be modified by the committee bill, is actuarially sound.

FINANCING POLICY

CONTRIBUTION RATE SCHEDULE FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE IN THE COMMITTEE BILL

The contribution schedule for old-age, survivors, and disability insurance contained in the committee bill, as to the combined employer-employee rate, is lower than that under present law by 0.4 percent in 1971-72, and by 1.2 percent in 1973-74, is the same in 1975-79, and is 1.0 percent higher in 1980-85, and 2.2 percent higher in 1986 and after. The maximum earnings base to which these tax rates are applied is \$9,000 per year for 1971 and after under the committee bill, the same as in the House-approved bill, as compared with \$7,800 under present law. These tax schedules are as follows:

[Percent]

Calendar year	Combined employer-employee rate			Self-employed rate		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970.....	8.4	8.4	8.4	6.3	6.3	6.3
1971-72.....	9.2	8.4	8.8	6.9	6.3	6.6
1973-74.....	10.0	8.4	8.8	7.0	6.3	6.6
1975-79.....	10.0	10.0	10.0	7.0	7.0	7.0
1980-85.....	10.0	11.0	11.0	7.0	7.0	7.0
1986 and after.....	10.0	11.0	12.2	7.0	7.0	7.0

The allocated rates to the two trust funds that are applicable to the combined employer-employee contribution rate for the committee bill, as compared with present law and the House-approved bill, are as follows:

[In percent]						
Calendar year	Old-age and survivors insurance			Disability insurance		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970-----	7.30	7.30	7.30	1.10	1.10	1.10
1971-----	8.10	7.50	7.90	1.10	.90	.90
1972-----	8.10	7.50	7.85	1.10	.90	.95
1973-74-----	8.90	7.50	7.85	1.10	.90	.95
1975-79-----	8.90	8.95	8.95	1.10	1.05	1.05
1980-85-----	8.90	9.85	9.65	1.10	1.15	1.35
1986 and after-----	8.90	9.85	10.75	1.10	1.15	1.45

The corresponding allocated rates for the self-employed contribution rate are as follows:

[In percent]						
Calendar year	Old-age and survivors insurance			Disability insurance		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970-----	5.475	5.4750	5.4750	0.825	0.8250	0.8250
1971-----	6.075	5.6250	5.9250	.825	.6750	.6750
1972-----	6.075	5.6250	5.8875	.825	.6750	.7125
1973-74-----	6.175	5.6250	5.8875	.825	.6750	.7125
1975-79-----	6.175	6.2125	6.2650	.825	.7875	.7350
1980-85-----	6.175	6.1375	6.1400	.825	.8625	.8600
1986 and after-----	6.175	6.1375	6.1700	.825	.8625	.8300

It should be remembered that the workers and employers contribute a combined, rounded rate for the two programs (old-age and survivors insurance and disability insurance), and not the above complex fractional rates separately. Such fractional rates are merely used by the Treasury Department to divide up the aggregate tax receipts between the two trust funds.

The schedule of allocation rates for the disability insurance trust fund in the committee bill has been obtained in the following manner.

The combined employer-employee rates, rounded to the nearest 0.05 percent of taxable payroll, were determined for the short-range years

that would produce the same relative accumulation of funds as in the Old-Age and Survivors Insurance Trust Fund. The remainder of the schedule was calculated to produce, as close as possible, an exact actuarial balance on the basis of rates rounded to 0.05 percent of taxable payroll.

The self-employed tax allocation was determined by allocating to the Disability Insurance Trust Fund the same proportion of the self-employed rate as was determined for the combined employer-employee rate. The resulting rates were rounded to the nearest 0.0005 percent of taxable payroll.

The allocation rates for the old-age and survivors insurance trust fund were obtained by merely subtracting the allocation rates for the disability insurance trust fund from the appropriate total tax rates.

SELF-SUPPORTING NATURE OF SYSTEM

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and thus actuarially sound.

ACTUARIAL SOUNDNESS OF SYSTEM

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is frequently not the case for well-administered private pension plans, which may not, as of the present time, have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs over the long-range period considered in the actuarial valuation. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite

proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group during the period considered in the valuation. The additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long-range period considered in the valuation, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

The committee believes that it is a matter for concern if the old-age, survivors, and disability insurance system shows any significant actuarial insufficiency. Since 1965 (when the cost estimates were first made on a 75-year basis), the view has been held that, if such actuarial insufficiency has been no greater than 0.10 percent of payroll, it is at the point where it is within the limits of permissible variation. However, reevaluation of the costs of the program—in light of rising wage levels—since then have shown that a somewhat higher variation may be allowable.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in the committee bill are in close conformity with these financing principles.

BASIC ASSUMPTIONS FOR COST ESTIMATES

GENERAL BASIS FOR LONG-RANGE COST ESTIMATES

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors, and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1980 and after) have usually been presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. It has not been possible, in the time available, to prepare such range estimates for this report, but rather only an intermediate-cost estimate, which is used to indicate the basis for the

financing provisions. This estimate is based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1970. The use of 1970 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently). In 1971, the aggregate amount of earnings taxable under the program with the proposed \$9,000 earnings base is estimated at \$469 billion. Of course, for future years the total taxable earnings are estimated to increase, because there will be larger numbers of covered workers.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with both prior and subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2015, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

MEASUREMENT OF COSTS IN RELATION TO TAXABLE PAYROLL

In general, the costs are shown as percentages of taxable payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to a great extent, its income. The result is that the cost relative to payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of \$400 per month. Under the committee bill such an individual would have a primary insurance amount of \$194.40. If his earnings rate should be 50 percent higher (i.e. \$600), his primary insurance amount would be \$258.10. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 33 percent. Or to put it another way, when his earnings rate was \$400 per month, his primary insurance amount represented 48.6 percent of his earnings, whereas, when his earnings increased to \$600 per month, his primary insurance amount relative to his earnings decreased to 43.0 percent.

GENERAL BASIS FOR SHORT-RANGE COST ESTIMATES

The short-range cost estimates (shown for the individual years 1970-75) are not presented on a range basis since—assuming that employment and earnings will increase each year it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future (about 5-6 percent per year), somewhat below that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

LEVEL-COST CONCEPT

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the trust funds would result, and in consequence there would be a sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

FUTURE EARNINGS AND CONSUMER PRICE INDEX ASSUMPTIONS

The long-range estimates for the old-age, survivors, and disability insurance program presented in this report are based on the assumption that the consumer price index and the average earnings covered by the program will remain level in the future. This does not mean covered payrolls are assumed to be the same each year; rather they will rise steadily as the covered population at the working ages is estimated to increase. If in the future the level of earnings and the consumer price index should continue to increase, as they have done in the past, the program would slowly accumulate actuarial surpluses. Under the financing procedures that were adopted by the committee to cover the cost of the automatic increases in benefits, the long-range level-cost of the automatic increases in benefits would be covered by increases in the tax rates and in the taxable earnings base that would be promulgated by the Secretary of the Department of Health, Education, and Welfare to become effective at the same time as the benefit increases.

The automatic benefit increases are designed as a backup to specific legislated increases to assure that rises in the cost of living will not, over a period of time, reduce the purchasing power of social security benefits. Therefore, realistic estimates of the cost of these benefits over a significant number of years are not possible. However, it is estimated that in the next decade the average cost of an annual cost-of-living increase might require an increase of about \$750 in the tax base and an increase of about 0.1 percent in the combined employee-employer tax rates.

INTERRELATIONSHIP WITH RAILROAD RETIREMENT SYSTEM

An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service and also for all survivor cases.

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that, over the long range, the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings.

REIMBURSEMENT FOR COSTS OF PRE-1957 MILITARY SERVICE WAGE CREDITS

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. These financing provisions were modified by the 1965 amendments. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of the law. These reimbursements are intended to be made on the basis of a constant annual amount (as determined by the Secretary of Health, Education, and Welfare) for each trust fund payable over the period up to the year 2015 (with such amount subject to adjustment every 5 years).

REIMBURSEMENT FOR COSTS OF ADDITIONAL POST-1956 MILITARY SERVICE WAGE CREDITS

Under the committee bill, individuals in active military service during 1957-67 will receive additional wage credits in excess of their cash pay (but within the maximum creditable earnings base) in recognition of their remuneration that is payable in kind (e.g., quarters and meals). These additional credits are at the rate of \$300 per calendar quarter. (Under the 1967 amendments, additional noncontributory wage credits of up to \$100 per month were granted for military service performed after 1967. The committee bill also modifies the way in which these credits are determined, from \$100 per month to \$300 per quarter.) The additional costs that arise from these credits are to be financed from general revenues on an "actual disbursements cost" basis, with reimbursement to the trust funds on as prompt a basis as possible (and with interest adjustments to make up for any delay due to the time needed to make the necessary actuarial calculations from sample data and for the necessary appropriations to be made).

In many instances, the availability of these additional wage credits will not result in additional benefits because the individual will have maximum credited earnings without them or because the year in which such credits are granted will be a drop-out year in the computation of his average monthly wage. In the immediate-future years, the cost of these additional credits to the general fund will be relatively small (only about \$35 million a year) since there will be relatively few cases arising, almost all due to death and disability.

ACTUARIAL BALANCE OF PROGRAM IN PAST YEARS

ACTUARIAL BALANCE OF PROGRAM AFTER ENACTMENT OF 1967 ACT ¹

The changes made by the 1967 amendments involved an increased cost that was fully met by the accompanying changes in the financing provisions (namely, an increase in the contribution rates in 1973 and after and an increase in the earnings base). After an increase in the allocation to the disability insurance system, both that portion of the program and the old-age and survivors insurance portion were estimated to be in close actuarial balance.

In 1968 the cost estimates were completely revised, based on the availability of new operating data. The new estimates showed significantly lower costs. The actuarial balance of the old-age, survivors, and disability insurance program increased from +0.01 percent of taxable payroll to +0.53 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1968 earnings assumption (instead of 1966 earnings) +0.33 percent; (2) use of 4¼ percent interest assumption (instead of 3¾ percent), +0.11 percent; (3) use of higher female labor force participation rates, +0.06 percent; and (4) other factors, +0.02 percent.

Then, in 1969, another complete revision of the actuarial cost estimates was made. The estimated cost of the program was again significantly reduced. The actuarial balance of the old-age, survivors, and disability insurance program was thereby increased from the figure of +0.53 percent of taxable payroll according to the 1968 estimate to +1.16 percent of taxable payroll. The factors contributing to lower costs were as follows: (1) use of 1969 earnings assumption (instead of 1968 earnings), +0.22 percent; (2) use of 4¾-percent interest assumption (instead of 4¼ percent), +0.11 percent; (3) use of higher labor force participation rates, for both men and women, +0.23 percent; and (4) other factors, +0.07 percent.

ACTUARIAL BALANCE OF PROGRAM AFTER ENACTMENT OF 1969 ACT

According to the cost estimates for the 1967 act made in 1969, there was a very favorable actuarial balance for the combined old-age, survivors, and disability insurance system, but that there was a deficit of 0.01 percent of taxable payroll for the disability insurance portion, and a favorable balance of 1.17 percent of taxable payroll for the old-age and survivors insurance portion.

Under the 1969 act, the benefit changes made were financed by utilizing the existing favorable actuarial balance, without any increases in the contribution rates and the earnings base. Accordingly, since the disability insurance system was in such close actuarial balance under the then-existing law, it was necessary to increase the portion of the combined contributions which were allocated to it, so as to finance the cost of the 15-percent benefit increase. Under the new allocation basis, both the old-age and survivors insurance system and the disability insurance system were in close actuarial balance.

¹ For details of the actuarial balance of the program before the enactment of the 1967 act, see page 83, H. Rept. 544, 90th Cong.

ACTUARIAL BALANCE OF PROGRAM UNDER THE COMMITTEE BILL

Table I traces through the change in the actuarial balance of the system from its situation under present law, according to the latest estimate, to that under the committee bill, by type of major changes involved, determined as of January 1, 1970.

TABLE I—CHANGES IN ACTUARIAL BALANCE OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, BY TYPE OF CHANGE, INTERMEDIATE-COST ESTIMATE, PRESENT LAW AND COMMITTEE BILL

[In percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system.....	-0.08	0.00	-0.08
Effect of using 1970 earnings.....	+.25	+.03	+.28
Increase in earnings base.....	+.20	+.03	+.23
Age 62 computation point for men.....	-0.7	(1)	-.07
Earnings test changes.....	-.13	(1)	-.13
Widow's benefits 100 percent PIA at 65.....	-.20	(2)	-.20
Liberalized eligibility for blind.....	(2)	-.08	-.08
4-month disability waiting period.....	(2)	-.06	-.06
Family maximum for new beneficiaries.....	-.03	-.01	-.04
Miscellaneous changes ³	-.01	(1)	-.01
10 percent benefit increase and \$100 minimum.....	-1.11	-.13	-1.24
Revised contribution schedule.....	+1.04	+.21	+1.25
Total effect of changes in bill.....	-.06	-.01	-.07
Actuarial balance under bill.....	-.14	-.01	-.15

¹ Less than 0.005 percent.

² Not applicable to this program.

³ Includes the following: child's benefits for children disabled at ages 18 to 21; disabled-child 7 years re-entitlement; reduced widower's benefits at age 60, and broaden definition of adopted child.

The changes made by the committee bill would maintain the sound actuarial position of the old-age, survivors, and disability insurance system. The estimated actuarial balance of -0.15 percent of taxable payroll is not quite inside the established limit within which the system is considered substantially in actuarial balance (i.e. -0.10 percent of taxable payroll), but—as pointed out earlier—the difference is small in light of rising earnings levels and should be made up when a new actuarial valuation is made in the latter part of 1971, when data on 1971 earnings become available.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

LEVEL-COST OF BENEFIT PAYMENTS, BY TYPE

The level-cost of the old-age and survivors insurance benefit payments (without considering administrative expenses, the railroad retirement financial interchange, and the effect of interest earnings on the existing trust fund) under the 1969 act, according to the latest intermediate-cost estimate, is 8.90 percent of taxable payroll, and the corresponding figure for the program as it would be modified by the committee bill is 9.98 percent. The corresponding figures for the disability benefits are 1.10 percent for the 1969 act and 1.32 percent for the committee bill.

Table II presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of the committee bill, separately for each of the various types of benefits.

TABLE II.—ESTIMATED LEVEL-COST OF BENEFIT PAYMENTS, ADMINISTRATIVE EXPENSES, AND INTEREST EARNINGS ON EXISTING TRUST FUND UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, AFTER ENACTMENT OF COMMITTEE BILL, AS PERCENTAGE OF TAXABLE PAYROLL,¹ BY TYPE OF BENEFIT, INTERMEDIATE-COST ESTIMATE

[In percent]

Item	Old-age and survivors insurance	Disability insurance
Primary benefits.....	6.80	1.09
Wife's and husband's benefits.....	.53	.07
Widow's and widower's benefits.....	1.62	(2)
Parent's benefits.....	.01	(2)
Child's benefits.....	.81	.16
Mother's benefits.....	.14	(2)
Lump-sum death payments.....	.07	(2)
Total benefits.....	9.98	1.32
Administrative expenses.....	.13	.04
Railroad retirement financial interchange.....	.09	.00
Interest on existing trust fund ³	-.24	-.04
Net total level-cost.....	9.96	1.32

¹ Including adjustment to reflect the lower contribution rate on self-employment income and on tips, as compared with the combined employer-employee rate.

² This type of benefit is not payable under this program.

³ This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

INCOME AND OUTGO IN NEAR FUTURE

Under the committee bill, benefit disbursements under the old-age, survivors, and disability insurance program will increase, over present law, by about \$6.7 billion in 1972, the first full calendar year of operation under the modified program. The contribution income for the old-age, survivors, and disability insurance program in 1972 is about \$0.8 billion higher than under present law (table III). Although these estimates are on a level-cost basis, the idea underlying the estimates assumes that Congress will continue, as in the past, to legislate specific benefit increases which take into account changes in earnings and price levels. Therefore, these estimates, and the others in this section, assume no automatic increases in benefit rates under the cost-of-living provision.

Under the program as modified by the committee bill, the old-age and survivor's trust fund will increase slowly during 1971-74, rising from \$32.3 billion at the end of 1970 to \$37.3 billion at the

end of 1974. During this period the amount of annual increase will rise from about \$0.2 billion in 1971 to about \$2.6 billion in 1974. Then, in 1975, when the contribution rates increase (the combined employer-employee rate going from 8.8 percent to 10.0 percent), the trust fund increases by \$9.3 billion; such large increases will also occur in the years immediately following 1975 (table IV). The trust fund balance at the end of each year during the period 1970-74 will amount to approximately 90 percent of the following year's outgo for benefit payments.

The disability insurance trust fund is estimated to increase by about \$0.1 billion in 1971, and by somewhat larger amounts each year thereafter, through 1974, when the fund increases by about \$0.4 billion. The increase in 1975 will be about \$1.0 billion, reflecting the increase from 0.95 percent in 1974 to 1.05 percent in 1975, in the combined employer-employee contribution rate allocated to the fund. The balance in the disability insurance trust fund will increase from \$5.6 billion at the end of 1970 to \$6.5 billion at the end of 1974, and then to \$7.5 billion at the end of 1975 (table V). The trust fund balance at the end of each year during the period 1970-74 will be approximately 1.3 times the amount of benefit payments in the following year.

TABLE III.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUNDS, COMBINED, SHORT RANGE ESTIMATE

[In millions]

Calendar year	Income		Disbursements			Net increase in funds	Funds at end of year
	Contributions ¹	Interest on fund	Benefit payments ²	Administrative expenses	Railroad retirement financial interchange		
Past experience:							
1960-----	\$11, 876	\$569	\$11, 245	\$240	\$314	\$647	\$22, 613
1961-----	12, 323	614	12, 749	303	337	-451	22, 162
1962-----	13, 105	594	14, 461	322	372	-1, 456	20, 705
1963-----	15, 640	587	15, 426	348	442	10	20, 715
1964-----	16, 843	633	16, 223	375	422	456	21, 172
1965-----	17, 205	651	18, 311	418	459	-1, 331	19, 841
1966-----	22, 679	702	20, 051	393	469	2, 467	22, 308
1967-----	25, 518	896	21, 417	515	539	3, 942	26, 250
1968-----	27, 448	1, 045	24, 954	603	458	2, 479	28, 729
1969-----	32, 004	1, 342	26, 767	612	513	5, 453	34, 182
Estimated future experience under committee bill:							
1970 ³ -----	34, 987	1, 821	31, 894	623	589	3, 702	37, 884
1971-----	39, 366	1, 920	39, 539	810	617	320	38, 204
1972-----	42, 202	1, 985	41, 797	812	778	800	39, 004
1973-----	44, 647	2, 117	43, 274	869	867	1, 754	40, 758
1974-----	47, 206	2, 303	44, 779	885	840	3, 005	43, 763
1975-----	55, 694	2, 691	46, 316	892	827	10, 350	54, 113

¹ Includes reimbursements from general fund of Treasury for costs of Treasury for costs of noncontributory credits for military service and payments to noninsured persons aged 72 and over.

² Includes payments for vocational rehabilitation services.

³ Under present law.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

TABLE IV.—PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Income		Disbursements			Net increase in funds	Funds at end of year
	Contributions ¹	Interest on fund	Benefit payments ²	Administrative expenses	Railroad retirement financial interchange		
Past experience:							
1960.....	\$10,866	\$516	\$10,677	\$203	\$318	\$184	\$20,324
1961.....	11,285	548	11,862	239	332	-599	19,725
1962.....	12,059	526	13,356	256	361	-1,388	18,337
1963.....	14,541	521	14,217	281	423	143	18,480
1964.....	15,689	569	14,914	296	403	645	19,125
1965.....	16,017	593	16,737	328	436	-890	18,235
1966.....	20,658	644	18,267	256	444	2,335	20,570
1967.....	23,216	818	19,468	406	508	3,652	24,222
1968.....	24,101	939	22,643	476	438	1,483	25,704
1969.....	28,389	1,165	24,210	474	491	4,378	30,082
Estimated future experience under committee bill:							
1970 ³	30,539	1,542	28,799	461	579	2,242	32,324
1971.....	35,272	1,598	35,452	572	605	241	32,565
1972.....	37,695	1,655	37,382	600	754	614	33,179
1973.....	39,849	1,770	38,656	646	832	1,485	34,664
1974.....	42,123	1,932	39,975	650	807	2,623	37,287
1975.....	49,837	2,281	41,332	649	794	9,343	46,630

¹ Includes reimbursements from general fund of Treasury for costs of noncontributory credits for military service and payments to noninsured persons aged 72 and over.

² Includes payments for vocational rehabilitation services.

³ Under present law.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

TABLE V.—PROGRESS OF DISABILITY INSURANCE TRUST FUND, SHORT-RANGE ESTIMATE

[In millions]

Calendar year	Income		Disbursements			Net increase in funds	Funds at end of year
	Contribu- tions ¹	Interest on fund	Benefit payments ²	Admin- istrative expenses	Railroad retirement financial interchange		
Past experience:							
1960.....	\$1,010	\$53	\$568	\$36	—\$5	\$464	\$2,289
1961.....	1,038	66	887	64	5	148	2,437
1962.....	1,046	68	1,105	66	11	—69	2,368
1963.....	1,099	66	1,210	68	20	—133	2,235
1964.....	1,154	64	1,309	79	19	—188	2,047
1965.....	1,188	59	1,573	90	24	—440	1,606
1966.....	2,022	58	1,784	137	25	133	1,739
1967.....	2,302	78	1,950	109	31	290	2,029
1968.....	3,348	106	2,311	127	20	996	3,025
1969.....	3,615	177	2,557	138	21	1,075	4,100
Estimated future ex- perience under com- mittee bill:							
1970 ³	4,448	279	3,095	162	10	1,460	5,560
1971.....	4,094	322	4,087	238	12	79	5,639
1972.....	4,507	330	4,415	212	24	186	5,825
1973.....	4,798	347	4,618	223	35	269	6,094
1974.....	5,083	371	4,804	235	33	382	6,476
1975.....	5,857	410	4,984	243	33	1,007	7,483

¹ Includes reimbursements from general fund of Treasury for cost of noncontributory credits for military service.

² Includes payments for vocational rehabilitation services.

³ Under present law.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

LONG-RANGE OPERATIONS OF OASI TRUST FUND

Table VI gives the estimated operations of the old-age and survivors insurance trust fund under the program as it would be changed by

the committee bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since nearly all of the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty.

In every year after 1969 for the next 25 years, contribution income under the system as it would be modified by the committee bill is estimated to exceed old-age and survivors insurance benefit disbursements. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the intermediate long-range cost estimate (with a level-earnings assumption), reaching \$40 billion in 1980 and about \$115 billion at the end of this century. The trust fund is shown as being exhausted in about 62 years, which results from the small lack of actuarial balance, as indicated previously.

TABLE VI.—ESTIMATED PROGRESS OF OLD-AGE AND SURVIVORS INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL, LONG-RANGE INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments ¹	Administrative expenses	Interest on fund	Balance in fund at end of year
1980.....	\$50,481	\$47,286	\$714	\$1,550	\$40,505
1985.....	53,667	54,505	772	2,075	50,334
1990.....	63,564	61,888	830	3,018	73,106
1995.....	68,447	68,095	881	3,821	90,764
2000.....	73,942	71,885	920	4,870	115,118
2025.....	96,214	119,296	1,353	6,760	148,773
2040.....	110,534	138,606	1,558	(²)	(²)

¹ Includes effect of financial interchange with railroad retirement system.

² Fund exhausted in 2032.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the special benefits payable to certain noninsured persons aged 72 or over or for the additional benefits payable on the basis of noncontributory credit for military service after 1956—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

LONG-RANGE OPERATIONS OF DI TRUST FUND

The disability insurance trust fund, under the program as it would be changed by the committee bill, grows after 1969, according to the intermediate long-range cost estimate, as shown by table VII. In 1980, it is shown as being \$4 billion, while in 1990, the corresponding figure is \$14 billion. There is a small excess of contribution income over benefit disbursements for every year after 1969 for the next 25 years, and then the fund declines and is exhausted by 2024.

TABLE VII.—ESTIMATED PROGRESS OF DISABILITY INSURANCE TRUST FUND UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL, LONG-RANGE INTERMEDIATE-COST ESTIMATE

[In millions]

Calendar year	Contributions	Benefit payments ¹	Administrative expenses	Interest on fund	Balance in fund at end of year
1980.....	\$7, 129	\$6, 167	\$226	\$148	\$4, 277
1985.....	7, 591	7, 140	237	310	7, 653
1990.....	8, 674	7, 904	250	608	14, 455
1995.....	9, 341	8, 827	270	863	20, 033
2000.....	10, 098	10, 084	306	1, 078	24, 634
2025.....	13, 099	14, 583	439	(²)	(²)
2040.....	15, 044	17, 117	516	(²)	(²)

¹ Includes effect of financial interchange provision with railroad retirement system.² Fund exhausted in 2024.

Note: Contributions include reimbursement for additional cost of noncontributory credit for military service before 1957. No account is taken in this table of the outgo for the additional benefits payable on the basis of noncontributory credit for military service after 1956—or of the corresponding reimbursement therefor, which is exactly counterbalancing from a long-range cost standpoint.

Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

Table VIII shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by the committee bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs.

TABLE VIII.—ESTIMATED COST OF BENEFIT PAYMENTS OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM AS PERCENT OF TAXABLE PAYROLL,¹ UNDER SYSTEM AS MODIFIED BY COMMITTEE BILL

Calendar year	Old-age and survivors insurance benefits	Disability insurance benefits	Total benefits
1980.....	8.91	1.17	10.08
1985.....	9.70	1.27	10.97
1990.....	10.40	1.33	11.73
1995.....	10.65	1.38	12.03
2000.....	10.43	1.46	11.89
2025.....	13.34	1.62	14.96
2040.....	13.50	1.65	15.15
Level-cost ²	9.96	1.32	11.28

¹ Taking into account the lower contribution rate for self-employment income and tips, as compared with the combined employer-employee rate.² Level contribution rate, at an interest rate of 4.75 percent benefits after 1969 taking into account interest on the trust fund on December 31, 1969, future administrative expenses, the railroad retirement financial interchange provisions, and the reimbursement of noncontributory military-wage-credits cost.

Note: Estimates assume no automatic increases in benefit rates under the cost-of-living provision.

C. ACTUARIAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

SUMMARY OF ACTUARIAL COST ESTIMATES

The hospital insurance system, as modified by the committee bill, has an estimated cost for benefit payments and administrative expenses that is in approximate long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program has but a few years of operating

experience, but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one.

New long-range actuarial cost estimates for the hospital insurance system have recently been prepared. They show a significantly higher benefit cost than the previous estimates, which were used as the basis for the 1967 amendments.

These new cost estimates are based on revised assumptions as to the many factors involved in the hospital insurance program. Based on actual recent experience, the assumptions include higher unit costs in the future for hospital and other services covered by the program, an increasing trend in utilization of services, and somewhat higher increases in covered earnings that are subject to contributions. A detailed presentation of the new assumptions is contained in "Actuarial Study No. 71," issued by the Social Security Administration, Department of Health, Education, and Welfare, but some information on these matters is presented in the subsequent discussion here.

FINANCING POLICY

FINANCING BASIS OF COMMITTEE BILL

The contribution schedule contained in the committee bill for the hospital insurance program, under a \$9,000 taxable earnings base beginning in 1971, is as follows, as compared with that of present law:

[In percent]

Calendar year	Combined employer-employee rate			Self-employed rate		
	Present law	House-approved bill	Committee bill	Present law	House-approved bill	Committee bill
1970.....	1.2	1.2	1.2	0.60	0.6	0.6
1971-72.....	1.2	2.0	1.6	.60	1.0	.8
1973-74.....	1.3	2.0	1.8	.65	1.0	.9
1975.....	1.3	2.0	2.0	.65	1.0	1.0
1976-79.....	1.4	2.0	2.0	.70	1.0	1.0
1980-85.....	1.6	2.0	2.2	.80	1.0	1.1
1986.....	1.6	2.0	2.2	.80	1.0	1.1
1987 and after.....	1.8	2.0	2.2	.90	1.0	1.1

Only one provision of the committee bill would add to the cost of the hospital insurance program. This provision would authorize the Secretary of Health, Education, and Welfare to establish presumptive periods of coverage on the basis of a physician's certification for patients admitted to an extended care facility (ECF) or started on a home health plan. Unless disapproved in advance, coverage upon admission to an ECF would continue for the lesser of: (a) the initially certified period, (b) until notice of disapproval, or (c) 10 days. Administration of the home health benefit would follow essentially the same approach. It is believed that this provision might increase ECF admissions; however, some of the related hospital stays will be shortened. The net effect of this provision is estimated to be a level-cost of .03 percent of taxable payroll.

The bill contains a number of provisions which are intended to reduce the cost of the program. Among these provisions are the elimination of payments to certain providers of services who have abused

the program, the limitation of the payments to certain providers of services who furnish services which are determined to be unduly expensive, certain limitations on financial participation for supporting unnecessary capital expenditures, the possibility of increased economy under prospective-reimbursement experiments and demonstration projects, the limitation of reimbursement to customary charges in certain instances when these are less than reasonable cost, and the requirement of reasonable institutional planning. The actuaries have not found it possible to estimate the extent of these savings; accordingly, any savings resulting from these provisions represents a safety margin in the cost estimate.

Another provision is designed to establish at local levels professional standards review organizations (PSRO's) as primary professional quality and cost control mechanisms for all health care services provided under medicare (and medicaid). When PSRO's are fully operational, they will have the potential to reduce the program cost substantially. Although the effectiveness of such organizations has been demonstrated at various localities, there is no experience on a nationwide basis. Here, too, the actuaries have not found it possible to estimate the savings that will result from this provision at this time; the reductions in cost (as well as any short-run increase in administrative expenses in setting up PSRO's) due to this provision are not taken into account in the actuarial cost estimates at this time. As the hospital insurance program experience affected by the PSRO's emerges, it is the committee's hope that they can be incorporated in the future actuarial cost estimates.

A provision designed to simplify medicare reimbursement requires the uniform use of the departmental method of cost apportionment for most larger institutions. The estimated level-cost savings to the program due to this provision is .02 percent of taxable payroll.

Another change made by the committee bill would permit individuals to obtain their medicare coverage (both hospital insurance and supplementary medical insurance) through a health maintenance organization (a group practice prepayment plan or other capitation plan). In such instances, the medicare program would pay for such coverage on a capitation basis. The capitation rate shall be determined by using established actuarial methods. It is the sum of the following three components: (1) An adjusted net premium which is determined by adjusting each HMO's net premium rate (actuarial benefit cost of providing the services) for enrollees under age 65 for differences between people age 65 and over and those under age 65 as to their utilization of services. Adjustments should also be made to reflect underwriting requirements, and other relevant factors. The adjusted net premium rate shall not exceed 95 percent of the benefit costs that, according to actuarial estimates (which would take into account such factors as age and sex of the enrollees, geographical location of the organization, the selection of risks, and the enrollment rules of the organization and other relevant factors determined by actuarial principles), would otherwise have been payable with respect to such persons if they had not been members of such organizations; (2) A risk charge (retention minus administrative expenses) which is the lesser of (a) the adjusted net premium times the ratio of the weighted gross premium rate of enrollees under age 65 over the corresponding actual

benefit costs per capita plus administrative expenses per capita, or (b) 150 percent of the average dollar amount of risk charges per capita that such organization structured in the premium rate for all enrollees under age 65; and (3) An administrative allowance which reasonably represents the actual administrative costs of such organization but not to exceed 95 percent of the national average per capita cost of administrative expenses incurred by intermediaries and carriers (excluding auditing expenses) for the same time period. The committee believes very strongly that the actuarial determinations shall be performed by qualified actuaries experienced in health insurance programs.

No valid experience under the medicare program is available for the purpose of making any cost estimates of the effect of the health maintenance organization provision. To the extent that adequate actuarial analysis can be made in the future as to the actual operation of those organizations, there could be a significant reduction in the long-run cost of the medicare program.

In the early years of operation, however, there might be increased program costs, because the relatively few organizations of this type now in existence are being reimbursed only their actual costs, whereas under the provisions of the committee bill, they could, in the future, be reimbursed somewhat more than costs. On the other hand, if such organizations can supply the covered services at a lower cost than what would otherwise prevail, then in the future, if more of these organizations are formed, there might be a significant net savings to the program. Accordingly, the actuarial cost estimates have not been increased to reflect the possible short-range cost aspects of this provision for a different reimbursement basis for health maintenance organizations since it is possible that in the long run the provision will result in savings.

The committee bill also contains a provision that would eliminate payments under the medicare program for services covered by the Federal employees health benefits plan, beginning in 1972, unless such plan is modified to make available coverage supplementary to that under the medicare program. For the purposes of the actuarial cost estimates, no account is taken of any possible reduction in benefit payments under the medicare program on this account, because of the likelihood that such modification will occur.

The committee bill provides an opportunity for persons who are not otherwise eligible under the hospital insurance program to enroll, on a voluntary basis, and then to pay the estimated full cost of the benefit protection thus made available. Such voluntary elective individual coverage can also be obtained by States and other organizations on a group basis for their retired employees aged 65 and over who are not otherwise protected under the hospital insurance program.

In this area also, the actuarial cost estimates presented in this report do not take into account the effect of this provision for voluntary coverage of otherwise ineligible persons, since it is not possible to estimate how many of the approximately 250,000 persons eligible to so elect will actually do so; of these 250,000 persons, about 145,000 are covered under the Federal Employees Health Benefits plan and so are unlikely to elect the voluntary hospital insurance under the bill. Thus, approximately 100,000 persons are really potentially eli-

gible to elect. Furthermore, if the premium rate, which has been actuarially estimated at \$27 per month for the first year of operation, is adequate, there will be no net effect on the financial operations of the total program. In any event, whether or not such experience is favorable, there will be relatively little effect on the financial operations of the program, because of the small number of persons likely to be involved.

The hospital insurance program is completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base has thus far been the same under both programs. First, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). Second, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. Third, income tax withholding statements (forms W-2) show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. Fourth, the hospital insurance program covers railroad employees directly in the same manner as other covered workers, and their benefit payments are paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). Fifth, the financing basis for the hospital insurance system is determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years, instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one). Sixth, the contribution rate for self-employed persons is the same as for employees, whereas under old-age, survivors, and disability insurance, the self-employed pay 50 percent more at the present time.

SELF-SUPPORTING NATURE OF SYSTEM

Just as has always been the case in connection with the old-age, survivors, and disability insurance system, the committee has very carefully considered the cost aspects of the present hospital insurance system and proposed changes therein. In the same manner, the committee believes that this program should be completely self-supporting from the contributions of covered individuals and employers (the transitional uninsured group covered by this program have their benefits, and the resulting administrative expenses, completely financed from general revenues). Accordingly, the committee very strongly believes that the tax schedule in the law should make the hospital insurance system self-supporting over the long range as nearly as can be foreseen, and thus actuarially sound.

ACTUARIAL SOUNDNESS OF SYSTEM

The concept of actuarial soundness as it applies to the hospital insurance system is somewhat similar to that concept as it applies to the old-age, survivors, and disability insurance system (see discussion of this topic in another section), but there are important differences.

One major difference in this concept as it applies between the two different systems is that cost estimates for the hospital insurance program are made over a period of only 25 years in the future, rather than 75 years as in connection with the old-age, survivors, and disability insurance program. A shorter period for the hospital insurance program is necessary because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit. Although there is reasonable likelihood that the number of beneficiaries aged 65 and over will tend to increase over the next 75 years when measured relative to covered population (so that a period of this length is both necessary and desirable for studying the cost of the cash benefits under the old-age, survivors, and disability insurance program), it is far more difficult to make reasonable assumptions as to the trends of medical care costs and practices for more than 25 years in the future. In fact, experience with the hospital insurance program has shown that it is difficult even to project 5 years into the future.

It seems desirable to the committee that the hospital insurance program should be in close actuarial balance. In order to accomplish this result, the committee has revised the contribution schedule to meet this requirement, according to the underlying cost estimates.

HOSPITALIZATION DATA AND ASSUMPTIONS

PAST INCREASES IN HOSPITAL COSTS AND IN EARNINGS

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1955 and up through 1969.

TABLE A.—COMPARISON OF ANNUAL INCREASES IN HOSPITAL COSTS AND IN EARNINGS

[Percent]

Calendar year	Increase over previous year	
	Average wages in covered employment ¹	Average daily hospitalization costs ²
1956.....	5.7	4.5
1957.....	5.5	7.7
1958.....	3.3	8.6
1959.....	3.3	6.8
1960.....	4.3	6.8
1961.....	3.1	8.5
1962.....	4.2	5.3
1963.....	2.4	5.6
1964.....	3.1	6.9
1965.....	1.6	7.0
1966.....	4.4	8.3
1967.....	6.3	12.3
1968.....	7.0	13.5
1969.....	6.0	³ 14.0
Average for 1956-65.....	3.6	6.8
Average for 1966-69.....	5.9	12.0

¹ Data are for calendar years (based on experience in 1st quarter of year).

² Data are for fiscal years ending in September of year shown. Data are from American Hospital Association, and "hospitalization costs" represents total hospital expense per patient day.

³ Preliminary estimate made by Social Security Administration.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospital costs are based on a series of average daily expense per patient day (including not only room and board, but also other inpatient charges and other expenditures of hospitals) prepared by the American Hospital Association.

The annual increases in earnings fluctuated somewhat over the period up through 1965, although there were not very large deviations from the average annual rate of 3.6 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise fluctuated from year to year during this period, around the average annual rate of 6.8 percent.

During the period 1956-65, hospital costs increased at a faster rate than earnings. The differential between these two rates of increase fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 3.2 percent.

Following 1965, however, both earnings and hospital costs have risen sharply, the former at a rate of about 6 percent per year and the latter at about 12 percent per year. Thus, the differential rate of increase of hospital costs as against earnings was about 6 percent per year during 1966-69, as compared with 3 percent in the preceding decade. Or, to put it another way, in the past 15 years, hospital costs have increased at double the rate that earnings in general have. No change in this relationship is evident currently, so that relatively high increases in hospital costs seem likely in at least the next few years.

The Department of Health, Education, and Welfare estimates that, in the future, after the next few years, earnings will increase at a rate of about 4 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be.

EFFECT ON COST ESTIMATES OF RISING HOSPITAL COSTS

A major consideration in making cost estimates for hospital benefits, then, is how long and to what extent the tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future, and whether or not it may, in the long run, be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense.

In connection with this latter factor, there are possible counterbalancing factors. The higher costs involved for more refined and exten-

sive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making actuarial cost estimates for hospital benefits is that—unlike the situation in regard to cost estimates for monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the financing provisions of the system are kept up to date (insofar as the maximum taxable earnings base is concerned). The reason for this result is that hospital costs rise at least at the same rate over the long run as the total earnings level, whereas the contribution income rises less rapidly, unless the earnings base is kept up to date, than the total earnings level.

For these reasons, the cost estimates were previously based on the assumption that both hospital costs and the general level of earnings will increase in the future for the entire 25-year period considered, while at the same time the earnings base will not change. The present cost estimates no longer assume that the maximum taxable earnings base will not change, but rather that it will be increased in the future as in the past.

The committee is aware that such a modification represents a basic change from the way future financing of the hospital insurance program has previously been handled. However, there are a number of provisions in the committee bill which should result in savings but for which no savings have been reflected in the actuarial projections. It is the committee's hope that these provisions will offset any unanticipated further cost increases in the future.

The fact that the cost-sharing provisions (the initial hospital deductible and the coinsurance features) are on a dynamic basis which varies with hospital costs is taken into account as not requiring a higher cost estimate than would be needed if static conditions were assumed.

ASSUMPTIONS AS TO RELATIVE TRENDS OF HOSPITAL COSTS AND EARNINGS UNDERLYING COST ESTIMATE FOR COMMITTEE BILL

As indicated previously, the committee very strongly believes that the financing basis of the hospital insurance program should be developed on a conservative basis. Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-

utilization and medical-practice trends will be in the distant future.

The assumptions as to the short-term trend of hospital costs for the cost estimates presented here are shown in table B. As in the past, it is assumed that the greatest annual increases in hospital cost rates have already taken place.

TABLE B.—ASSUMPTIONS AS TO FUTURE RATES OF INCREASES IN HOSPITAL COSTS

Calendar year :	<i>Rate of increase (in percent)</i>
1969 -----	15.0
1970 -----	14.0
1971 -----	13.0
1972 -----	11.5
1973 -----	10.0
1974 -----	8.5
1975 -----	7.0
1976 -----	6.0
1977 -----	5.0
1978 and after -----	4.0

ASSUMPTIONS AS TO HOSPITAL UTILIZATION RATES UNDERLYING COST
ESTIMATES FOR COMMITTEE-APPROVED BILL

The hospital utilization assumptions for the cost estimates in this report are founded on the hypothesis that current practices in this field will not change even more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for your committee's bill are based on the actual experience of the program in 1968, with assumed increases of 1 to 2 percent per year for the next decade.

ASSUMPTIONS AS TO HOSPITAL PER DIEM RATES UNDERLYING COST
ESTIMATES FOR COMMITTEE-APPROVED BILL

The average daily hospital reimbursement rate by the program for 1968 (i.e. not including the cost-sharing payments made by the beneficiaries) was about \$48. This was projected for future years in the manner described previously.

RESULTS OF COST ESTIMATES

SUMMARY OF COST ESTIMATE FOR COMMITTEE BILL

The level-cost of the benefits and administrative expenses under present law is estimated at 2.11 percent of taxable payroll under the

assumption that the earnings base will be increased in the future as in the past. Such level-cost would be 2.79 percent of taxable payroll if it were assumed that the earnings base would remain fixed at \$7,800 over the entire 25-year valuation period—the assumption underlying previous actuarial evaluation of the program

Under the rising-earnings-base assumption, the level-equivalent of the graded contribution schedule under present law is 1.56 percent of taxable payroll and the level-equivalent value of the existing trust fund is 0.02 percent of taxable payroll, so that there is a lack of actuarial balance under present law, using the revised estimates of hospital cost trends and the other revised cost factors, amounting to 0.53 percent of taxable payroll. Under the assumption that the earnings base remains level in the future at the \$7,800 amount specified in present law (the assumption which has heretofore been made in setting the contribution schedule), the level-equivalent of the contribution schedule is 1.52 percent of taxable payroll, and the level-equivalent of the existing trust fund is 0.03 percent of taxable payroll, so that then the actuarial balance would be -1.24 percent of taxable payroll.

Under the committee bill, there would be additional financing for the program, both through the increase in the earnings base to \$9,000, effective in 1971, and through increasing the rates in the contribution schedule. Thus, the new contribution schedule (which has a level-equivalent value of 2.05 percent of taxable payroll) would, if the projected cost assumptions are valid, adequately finance the program, whose actuarial balance would then be -0.05 percent of taxable payroll.

Table C traces through the actuarial balance of the hospital insurance system from its situation under present law, according to the latest estimate, to that under the committee bill, determined as of January 1, 1970.

TABLE C.—CHANGES IN ACTUARIAL BALANCE OF HOSPITAL INSURANCE SYSTEM, EXPRESSED IN TERMS OF ESTIMATED LEVEL-COST AS PERCENTAGE OF TAXABLE PAYROLL, INTERMEDIATE-COST ESTIMATE, PRESENT LAW, HOUSE APPROVED BILL AND COMMITTEE BILL

[In percent]

Item	Level-cost or level-equivalent			
	Contributions	Benefit payments ¹	Existing trust fund	Actuarial balance
Present law, level \$7,800 earnings base	1.52	2.79	0.03	-1.24
Present law, increasing earnings base ²	1.56	2.11	.02	-.53
House approved bill, increasing earnings base ²	1.98	2.11	.02	-.11
Committee bill, increasing earnings base ²	2.05	2.12	.02	-.05

¹ Including also the administrative expenses.

² The cost estimate is made under the assumption that the maximum taxable earnings base will be increased after 1970, so that approximately the same proportion of the total payroll in covered employment will be taxable as was the case under the \$7,800 base in 1968. This would produce a base of \$9,000 in 1971-72 (as in the committee bill) and under the assumptions made as to future changes in earnings levels, \$9,600 in 1973-74, \$10,200 in 1975-76, \$11,400 in 1977-78, etc., to \$21,000 in 1993-94.

The cost for the persons who are blanketed-in for the hospital and related benefits is met from the general fund of the Treasury (with the financial transactions involved passing through the hospital insurance trust fund). The costs so involved, along with the financial transactions, are not included in the preceding cost analysis, although

they are shown in the following discussion of the progress of the hospital insurance trust fund. A later portion of this section discusses these costs for the blanketed-in group.

FUTURE OPERATIONS OF HOSPITAL INSURANCE TRUST FUND

Table D shows the estimated operation of the hospital insurance trust fund under present law (assuming no change in the \$7,800 earnings base), while table E gives similar figures for the committee bill (under the assumption that the \$9,000 earnings base effective in 1971 will be increased as earnings levels rise in the future).

Under present law, outgo exceeds income for every year after 1969. As a result, the trust fund is shown as being exhausted in mid-1972. According to this estimate, under the committee bill the balance in the trust fund would grow steadily in the future, increasing from about \$2.2 billion at the end of 1970 to \$5.9 billion 5 years later; over the long range, the trust fund would build up steadily, reaching \$22.4 billion in 1994, somewhat less than 1 year, ago.

TABLE D.—ESTIMATED PROGRESS OF HI TRUST FUND UNDER PRESENT FINANCING PROVISIONS, INCURRED BASIS

[In millions]

Calendar year	Contributions ¹	Government payment for uninsured ²	Benefit payments	Administrative expenses	Interest on fund ³	Net income	Fund at end of year
1970.....	\$4,973	\$618	\$5,820	\$140	\$139	—\$130	\$2,183
1971.....	5,231	656	6,894	150	101	—1,056	1,127
1972.....	5,482	685	8,031	161	8	—2,017	(⁴)

¹ Includes payments from general fund for military service wage credits.

² Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).

³ Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.

⁴ Fund exhausted in 1972.

Note: Fund balance at beginning of 1970 is \$2,413,000,000 on an incurred basis (as compared with \$2,505,000,000 on a cash basis.)

TABLE E.—ESTIMATED PROGRESS OF THE HI TRUST FUND UNDER FINANCING PROVISIONS OF COMMITTEE BILL UNDER BASIS OF EARNINGS BASE BEING INCREASED IN THE FUTURE,¹ INCURRED BASIS

[In millions of dollars]

Calendar year	Contributions ²	Payment from general fund for uninsured ³	Benefit payments	Administrative expenses	Interest on fund ⁴	Net income	Fund at end of year
1970.....	4,973	618	5,820	140	139	—230	2,183
1971.....	7,404	671	6,974	150	166	1,117	3,300
1972.....	7,784	700	8,111	161	208	420	3,720
1973.....	9,423	716	9,254	172	245	958	4,678
1974.....	9,853	716	10,433	183	275	228	4,906
1975.....	11,723	703	11,537	195	305	999	5,905
1976.....	12,211	680	13,592	207	311	—597	5,308
1977.....	13,326	646	12,615	219	329	1,467	6,775
1978.....	13,880	605	14,467	232	367	153	6,928
1979.....	14,763	558	15,322	246	368	121	7,049
1980.....	16,895	505	16,218	260	398	1,320	8,369
1985.....	22,238	292	21,472	345	718	1,431	15,431
1990.....	28,712	124	28,726	457	944	597	19,641
1994.....	35,732	48	35,670	560	1,077	627	22,395

¹ Maximum taxable earnings base would be \$7,800 in 1970, \$9,000 in 1971–72, \$9,600 in 1973–74, \$10,200 in 1975–76, \$11,400 in 1977–78, increasing ultimately to \$21,000 in 1993–94. Combined employer-employee contribution schedule would be 1.2 percent for 1970, 1.6 percent for 1971–72, 1.8 percent for 1973–74, 2.0 percent for 1975–79, and 2.2 percent for 1980 and after.

² Includes payment from general fund for military service wage credits.

³ Cost for benefit payments and accompanying administrative expenses for uninsured persons for each fiscal year is assumed to be paid to the trust fund in the middle of the fiscal year (i.e., at the end of the corresponding calendar year).

⁴ Over the long range, a 5-percent rate is assumed, with a somewhat higher rate in the early years.

COST ESTIMATE FOR HOSPITAL BENEFITS FOR NONINSURED PERSONS PAID
FROM GENERAL FUNDS

Hospital and related benefits are provided not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also on a "free" basis for most other persons who were aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. The exceptions are non-insured persons who are active and retired Federal employees who are eligible (or had the opportunity of being eligible) for similar protection under the Federal Employees Health Benefits Act of 1959 or who are short-residence aliens.

Under present law, persons meeting such conditions who attain age 65 before 1968 qualify for the hospital benefits regardless of whether they have had any covered employment in the past, while those attaining age 65 after 1967 must have some such coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1966 and before the year of attainment of age 65 (e.g., 3 quarters of coverage for attainment of age 65 in 1968, 6 quarters for 1969, etc.). This transitional provision "washes out" under present law for men attaining age 65 in 1975 and for women attaining age 65 in 1974, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

Under the committee bill, these requirements for noninsured men would "wash out" at the same time as for women (due to the "age-62 computation point for men" provision in the committee bill).

The benefits for the noninsured group who receive hospital insurance benefits on a "free" basis is to be paid from the hospital insurance trust fund, but with financial reimbursement therefor from the general fund of the Treasury on a current basis, or with appropriate interest adjustment. The estimated cost to the general fund of the Treasury for the hospital and related benefits for this noninsured group (including the applicable additional administrative expenses) for various future years is shown in Table E. The estimated cost to the general fund of the Treasury for the closed group involved increases slowly to a peak of about \$716 million per year in 1973-74 and then decreases steadily thereafter. Offsetting, in large part, the decline in the number of eligibles blanketed-in are the factors, the increasing hospital utilization per capita as the average age of the group rises and the increasing hospital costs in future years.

The foregoing discussion and cost estimates do not include the non-insured persons who, under the provisions of the committee bill, can voluntarily buy into the hospital program on the basis of their paying the estimated full costs involved.

D. ACTUARIAL COST ESTIMATES FOR THE SUPPLEMENTARY MEDICAL INSURANCE SYSTEM

SUMMARY OF ACTUARIAL COST ESTIMATES

The committee bill has broadened the benefit protection provided by the supplementary medical insurance program. Manual manipu-

lation of the spine by qualified chiropractors will be covered if the chiropractor meets certain minimum standards established by the Secretary of Health, Education, and Welfare.

The committee bill contains a number of provisions which will reduce the cost of the supplementary insurance program. Among these provisions is the establishment of limits on prevailing charges (using the 75th percentile upon enactment of the bill and adjusting the levels thereafter by means of an appropriate economic index) and the tightening up of the reimbursement provisions for teaching physicians who furnish services.

Also, the committee adopted certain provisions which have the potential of reducing the costs of the supplementary medical insurance program. Among these provisions are the limitation on the reimbursement of physical and other therapists, the establishment of professional standards review organizations, the establishment of the Office of Inspector General in the Department of Health, Education, and Welfare, the increased penalty for defrauding health care programs, the reasonable limitations on medicare allowances for routine follow-up visits, injections, and laboratory services, and the inclusion of Blue Shield payments in calculating reasonable charges. The actuaries have not been able to estimate the extent of the savings under these provisions; there could be a significant reduction in the long-run costs.

No account is taken in the actuarial cost estimates for the supplementary medical insurance program of the provisions of the committee bill that provide for medicare coverage to be obtained from health maintenance organizations or for medicare benefits to be withheld (after 1971) if benefits are payable to the individual under the Federal employees health benefits plan, unless such plan is coordinated with medicare.

The cost effects of these changes will be recognized by the Secretary of Health, Education, and Welfare in his determination of the standard premium rate for fiscal year 1972, which in accordance with the provisions of present law will be promulgated in December 1970.

FINANCING POLICY

SELF-SUPPORTING NATURE OF SYSTEM

Coverage under supplementary medical insurance can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and over in the United States. This program is intended to be completely self-supporting from the premiums of enrolled individuals and from the equal-matching contributions from the general fund of the Treasury. For the initial period, July 1966 through December 1967, the premium rate was established by law at \$3 per month, so that the total income of the system per participant per month was \$6. Persons who do not elect to come into the system at as early a time as possible generally have to pay a higher premium rate. The law requires that the standard monthly premium rate be adjusted annually by promulgation of the Secretary of Health, Education, and Welfare (using ap-

propriate actuarial methods), so as to reflect the expected experience on an incurred-cost basis, including an allowance for a margin for contingencies. All financial operations for this program are handled through a separate fund, the supplementary medical insurance trust fund.

ACTUARIAL SOUNDNESS OF SYSTEM

The concept of actuarial soundness for the old-age, survivors, and disability insurance system and for the hospital insurance system is somewhat different than that for the supplementary medical insurance program. In essence, the last system is on a "current cost" financing basis, rather than on a "long-range cost" financing basis. The situations are essentially different because the financial support of the supplementary medical insurance system comes from a premium rate that is subject to change from time to time, in accordance with the experience actually developing and with the experience anticipated in the near future. The actuarial soundness of the supplementary medical insurance program, therefore, depends only upon the "short-term" premium rates being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are established (including the accumulation and maintenance of a contingency fund).

RESULTS OF COST ESTIMATES

Both the bill passed by the House of Representatives and the committee bill make changes which have a significant cost effect. These changes are summarized in the following table along with the cost per participant per month relative to the current \$10.60 monthly premium rate (for participant and the Government combined) :

[Premium rate per month]

Item	Cost	
	House-approved bill	Committee bill
Limited coverage of chiropractic services.....		+\$0.22
Liberalized physical therapy benefits.....	+\$0.03	
Lower limits on prevailing charge levels.....	-.20	-.20
Total ¹	-.17	+.02

¹ Savings effect of other provisions of the bill not estimated.

The total cost of \$0.02 per month per capita is equivalent to an annual cost of \$4.7 million with respect to 19.6 million participants.

E. ACTUARIAL COST ESTIMATES FOR THE CATASTROPHIC HEALTH INSURANCE SYSTEM

INTRODUCTION

This section of the report presents the actuarial cost estimates for the catastrophic health insurance program established by the Social Security Amendments of 1970 approved by the committee. A summary

of the benefit, coverage, and financing provisions of the system is contained in previous sections.

SUMMARY OF ACTUARIAL COST ESTIMATES

The catastrophic health insurance program established by the committee bill has an estimated cost for benefit payments and administrative expenses that is in long-range balance with contribution income. It is recognized that the preparation of the cost estimates for hospital and physicians' services and related benefits is much more difficult and much more subject to variation than cost estimates for the old-age, survivors, and disability insurance system. It is also recognized that future experience can be different from the projections. This is not only because the catastrophic health insurance program will be newly established, with no past operating experience, but also because of the great number of variable factors in the underlying cost elements of covered medical services. It is essential as stated in the committee report, that the operations of this new program should be carefully studied as they occur in the future, so that the Congress and the executive branch can be kept well informed and on a timely basis. Under these circumstances, the committee has agreed with the practice which has been established with the title XVIII programs that there should be a small continuing actuarial sample (of perhaps 1 percent of all eligible individuals), so that the emerging experience can be analyzed promptly and thoroughly. In this connection, it will be essential for carriers and intermediaries involved in the processing and payment of claims to supply the necessary actuarial information promptly and in an adequate fashion for the actuarial analysis to be made.

FINANCING POLICY

FINANCING BASIS OF BILL

The contribution schedule contained in the committee-approved bill for the catastrophic health insurance program, on a maximum earnings base of \$9,000 in 1971 and assuming earnings base increases thereafter, is as follows:

Calendar year	Employer- employee rate (percent)	Self-employed rate (percent)
1972-74.....	0.6	0.3
1975-79.....	.7	.35
1980 and after.....	.8	.4

Although the taxable earnings base is the same for the catastrophic health insurance program as for the hospital insurance program, the financial operations of the two programs are completely separate. First, the catastrophic health insurance program will have a completely separate trust fund, as well as a separate Board of Trustees from that of the old-age, survivors, and disability insurance system and the hospital insurance and supplementary medical insurance systems. Secondly, the schedule of tax rates for the catastrophic health insurance program is in a separate subsection of the Internal Revenue Code.

SELF-SUPPORTING NATURE OF SYSTEM

The old-age, survivors, and disability and health insurance system has always been of a self-supporting nature. The committee has carefully considered the cost aspect in the proposed catastrophic health insurance program, and believes that this program should also be completely self-supporting from the contributions of covered individuals and employers. Accordingly, the committee very strongly believes the program should be financed on an actuarial sound basis. The tax schedule in the committee bill should make the catastrophic health insurance program self-supporting over the next 25 years.

ACTUARIAL SOUNDNESS OF SYSTEM

The concept of actuarial soundness as it applies to the catastrophic health insurance program is the same as it applies to the hospital insurance program.

The cost estimates for the catastrophic health insurance program are made over a period of 25 years in the future. Although it is difficult to predict the future trends of medical care costs and the change in medical technology for the next 25 years, it is feasible to make reasonable assumptions as to these factors. Another consideration is that changes in the population can be predicted with a higher degree of accuracy. The future costs of the program and financing thereof are in large part affected by population changes.

In starting a new program such as the catastrophic health insurance program, the committee believes that the program should be in actuarial balance. In order to accomplish this result, the committee has developed a contribution schedule that will meet this requirement, according to the underlying cost estimates.

RESULTS OF COST ESTIMATES

LEVEL-COST OF CATASTROPHIC HEALTH INSURANCE BENEFITS

The level-cost of the catastrophic health insurance benefits (including administrative expenses) that was adopted by the committee is estimated to be 0.80 percent of taxable payroll. Under the assumption that the maximum taxable earnings base will be \$9,000 in 1971 and increased in the future as in the past. The valuation period used in determining the level-cost is a 25-year period (1972-96), as explained previously.

The level equivalent of the contribution schedule in the bill over the same 25-year period, is 0.76 percent. Accordingly, these estimates indicate that the catastrophic health insurance program has an actuarial balance of -.04 percent of taxable payroll.

ASSUMPTIONS USED IN THE COST ESTIMATE

The benefit coverages provided by the catastrophic health insurance program are the same benefits as those currently provided under parts A and B of medicare except that there will be no limitations on hospital days, extended care facility days, or home health visits. However, the limitations on the psychiatric coverage remains unchanged (limited to 190 days of hospitalization in psychiatric hospitals during

a lifetime, also limited to \$312.50 of psychiatric medical expenses per calendar year). The program would not cover the first 60 days of hospital care in a calendar year (with a provision which allows the carry-over of hospital days from the last quarter of the previous year). Other medical expenses are subject to a \$2,000 deductible in each calendar year, which is kept on a dynamic basis. The program adopted by the committee would pay 80 percent of the reasonable cost of covered services above the deductibles.

There is only a relatively small amount of data available in regard to the insurance experience with respect to a catastrophic insurance plan as adopted by the committee. The data used in determining the actuarial cost estimate include information obtained from the national health survey, private health insurance experiences, and data from the national health expenditures series. The experience under the supplementary medical insurance program was also used.

Past increases in hospital costs

Table 1 presents a summary comparison of increases in hospital costs and the corresponding increases in wages that have occurred since 1955.

TABLE 1.—COMPARISON OF ANNUAL INCREASE IN HOSPITAL COSTS AND IN WAGES
(In percent)

Year	Increase over previous year	
	Average wages in covered employment ¹	Average daily hospitalization costs ²
1956	5.7	4.5
1957	5.5	7.7
1958	3.3	8.6
1959	3.3	6.8
1960	4.3	6.8
1961	3.1	8.5
1962	4.2	5.3
1963	2.4	5.6
1964	3.1	6.9
1965	1.6	7.0
Average for 1956-65	3.6	6.8
1966	4.4	8.3
1967	6.3	12.3
1968	7.0	13.5
1969	6.0	³ 14.0
Average for 1960-69	4.2	8.8

¹ Data are for calendar years (based on experience in 1st quarter of year).

² Data are for fiscal years ending in September of year shown. Data are from American Hospital Association, and "hospitalization costs" represents total hospital expense per patient day.

³ Preliminary estimate made by Social Security Administration.

The annual increase of earnings are based on the covered employment under the old-age, survivors, and disability insurance system as indicated by the first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The increases in hospitalization costs are mostly based on a series of average daily costs published by the American Hospital Association. However, the series published by the AHA is only related to the short-term hospitals.

The annual increase in hospital costs have fluctuated around an average rate of 6.8 percent between 1956 to 1965, while the annual rate of increase in average wages in covered employment was 3.6 percent during the same period. On the other hand, since 1965, the annual rate of increase in daily hospitalization costs has been rising more rapidly. The actuarial cost estimate for the catastrophic health in-

surance program used the assumptions as shown in table 2. For the earlier years, it reflects the most recent trends, with the series generally decreasing to the long-term historical experiences.

In the past, the hospital utilization rates have been increasing. This phenomenon is caused by numerous factors including the change in medical technology, higher income per capita, and greater insurance coverage. The long-term trend used in this actuarial cost estimate assumes that the historical trend will continue in the future.

TABLE 2.—ASSUMPTIONS AS TO FUTURE INCREASES IN INPATIENT HOSPITAL COST ELEMENTS

[In percent]

Calendar year:	Inpatient hospital	
	Average daily cost	Utilization rate
1973.....	14.0	2.0
1974.....	14.0	2.0
1975.....	13.0	2.0
1976.....	11.0	2.0
1977.....	9.5	1.5
1978.....	8.5	1.5
1979.....	8.5	1.5
1980.....	7.0	1.0
1981 and after.....	6.0	1.0

Physician services

Table 3 summarizes the past trend of physician charges as reported by the Consumer Price Index. The annual increase in physicians' fees, as measured by the Consumer Price Index, have fluctuated around the average rate of 3.1 percent between 1956 to 1965, while the average annual rate of increase in average wages in covered employment was 3.6 percent during the same period. On the other hand, since 1965, the annual rate of increase in physicians' fees have been rising more rapidly.

The assumptions used for future years appear in table 4. As in the past, it is assumed that the largest annual fee increases have already occurred. For the early years, the recent increasing trend in the physician charges is used. The series gradually decreases thereafter to the long-term historical trend.

TABLE 3.—AVERAGE ANNUAL INCREASE IN PHYSICIANS' FEES AND IN WAGES

[In percent]

Calendar year	Physicians' fees ¹	Average wages in covered employment ²
1956.....	3.0	5.7
1957.....	4.3	5.5
1958.....	3.4	3.3
1959.....	3.4	3.3
1960.....	2.5	4.3
1961.....	2.5	3.1
1962.....	2.9	4.2
1963.....	2.2	2.4
1964.....	2.5	3.1
1965.....	3.4	1.6
Average, 1956-65.....	3.1	3.6
1966.....	5.8	4.4
1967.....	7.1	6.3
1968.....	5.6	7.0
1969.....	7.0	6.0
Average, 1960-69.....	4.7	4.2

¹ As measured by the Consumer Price Index of physician fees.

² Data are for calendar years (based on experience in 1st quarter of year).

There is a long-term trend in the United States in the increasing use of physician services per capita. This amounts to an annual rate of 1 to 2 percent increase. This phenomenon is taken into account in the cost estimate.

TABLE 4.—ASSUMPTIONS AS TO COST ELEMENTS OF PHYSICIANS' SERVICES

[In percent]

Calendar year	Increase over previous year	
	Physician fees	Utilization rate
1972.....	6.0	2.5
1973.....	5.5	2.2
1974.....	5.0	2.2
1975.....	4.5	2.0
1976 and after.....	4.0	2.0

NUMBER OF PERSONS PROTECTED ON JANUARY 1, 1972

All wage earners under age 65 who are fully or currently insured under the social security program, their spouse and minor children and persons under age 65 receiving disability benefits will be eligible for the catastrophic health insurance protection. This constitutes about 95 percent of all persons under age 65. It is estimated that in 1972 approximately 180 million people in the United States will be protected by this program.

Persons age 65 and over will not be covered under the catastrophic health insurance program because these persons are protected under the medicare program. The largest noncovered group under age 65 will be those Federal employees who are not fully or currently insured under social security. However, these employees are eligible for both basic and catastrophic health insurance protection under the Federal Employee Health Benefit Act.

There are a small number of other citizens who are still not covered by social security. The majority of these are domestic or agricultural workers who have not met the necessary coverage requirements.

ADMINISTRATIVE EXPENSES

The administrative expenses in connection with the catastrophic health insurance program, including those of fiscal intermediaries, are calculated on the assumption that they will represent 5 percent of the benefit cost. This total amount is projected to increase in the future at the same rate of increase as general wages.

INTEREST RATE

An interest rate of 5 percent is used in determining the level costs of the benefit payments and administrative expenses and the level equivalent of the contributions. However, in developing the progress

of the trust fund, higher rates are used in the first few years—namely, 6 percent in 1972, gradually declining to a level of 5 percent by 1982 and thereafter.

ASSUMPTIONS AS TO FUTURE INCREASES IN EARNINGS IN COVERED EMPLOYMENT

The increase in average earnings in covered employment has been about 6–7 percent per year since 1967. It is assumed that the annual rate of increase will decline gradually in the future, to an ultimate rate of 4 percent by 1976.

Under the committee's bill, the maximum taxable earnings base is \$9,000 in 1971. For estimating the actuarial costs, it was assumed the earnings base will be increased in the future as in the past. With this assumption, the taxable payroll will rise in close relationship to the increase in general earnings. Table 5 shows the assumptions used in future increases in the average total earnings.

Table 5.—Projection of wage increases in covered employment

Calendar year:	Average earnings (percent)
1972	5.0
1973	4.6
1974	4.3
1975	4.1
1976 and after.....	4.0

FUTURE OPERATIONS OF THE CATASTROPHIC HEALTH INSURANCE TRUST FUND

Table 6 shows the estimated operation of the catastrophic health insurance trust fund under the bill adopted by the committee. According to this estimate, the balance in the trust fund would grow steadily in the intermediate future, increasing from about \$400 million at the end of 1972 to \$2.5 billion 5 years later. The trust fund is estimated to reach \$6.9 billion in 1995.

TABLE 6.—ESTIMATED PROGRESS OF THE CATASTROPHIC INSURANCE TRUST FUND UNDER FINANCING PROVISIONS OF COMMITTEE BILL UNDER BASIS OF EARNINGS BASE BEING INCREASED IN THE FUTURE,¹ INCURRED BASIS

	Contributions	Benefit payments	Administrative expenses	Interest	Net income	Fund at end of year
Calendar year:						
1972.....	\$2,915	\$2,380	\$120	\$13	\$428	\$428
1973.....	3,137	2,692	126	35	354	782
1974.....	3,281	3,037	132	49	161	943
1975.....	4,099	3,404	137	71	629	1,572
1976.....	4,270	3,790	143	99	436	2,008
1977.....	4,660	4,180	149	122	453	2,461
1978.....	4,854	4,575	155	139	263	2,724
1979.....	5,163	4,963	161	148	187	2,911
1980.....	6,140	5,371	167	170	772	3,683
1985.....	8,082	7,576	204	353	655	7,557
1990.....	10,437	10,626	248	455	18	9,343
1995.....	14,029	14,904	301	357	-819	6,900
1996.....	14,562	15,947	314	302	-1,397	5,503

¹ Maximum taxable earnings base would be \$9,000 in 1972, \$9,600 in 1973–74, \$10,200 in 1975–76, \$11,400 in 1977–78, increasing to \$21,000 in 1993–94. Combined employer–employee contribution schedule would be 0.6 percent for 1972–74, 0.7 percent for 1975–79, 0.8 percent for 1980 and after.

VII. TRADE ACT OF 1970

Trade Act of 1970

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VII. TRADE ACT OF 1970

A. BACKGROUND

The committee trade amendment accomplishes many needed reforms in our tariff and trade laws which are long overdue. The last time the Congress had an opportunity to pass extensive trade legislation was in 1962 in the so-called Trade Expansion Act. That Act provided authority for the President to enter into trade negotiations, popularly known as the "Kennedy Round."

Since July 1, 1967, the President has been without negotiating authority. Moreover, since the end of the "Kennedy Round," many United States industries and their employees have been subject to sharply increasing import competition, which, in many cases, has resulted in shutdowns of plant and equipment and loss of American jobs.

The Committee on Finance has been very concerned about the impact of rapidly rising imports on the American economy. It has examined this question in depth on a number of occasions since 1967. Shortly after the end of the Kennedy Round, in October 1967, the committee held hearings on proposed import quota legislation. At that time, the committee heard from many witnesses expressing various points of view on import problems. The hearing record covered 1,218 pages. Thereafter in February 1968 the committee published a compendium of papers dealing with foreign trade issues. Again, a broad range of views was presented which dealt with very specific issues in our foreign trade relations. The executive branch participated in both the 1967 hearings and the 1968 compendium of papers. Moreover, the committee initiated a study of the effect of steel imports on our economy, and also examined unfair trade practice statutes in its consideration of the International Antidumping Code.

On two occasions, the Senate itself expressed its concern over outstanding import problems. On March 27, 1968, the Senate approved a floor amendment to a major tax bill by a vote of 55 to 31 which would have imposed import quotas on textile and apparel products. The members of the House of Representatives participating in the conference at that time were unwilling to accept the Senate amendment. On December 10, 1969, the Senate again passed an amendment to another major tax bill, expressing its concern over foreign nontariff barriers and the need to protect American industries and jobs. Once again, the Members of the House of Representatives choose not to accept the Senate amendment.

In the meantime, the Committee on Ways and Means held extensive hearings on trade legislation in the past two years. In 1968, the House committee held a series of hearings on the then administration's trade bill which covered 10 volumes and 5,099 pages. This year, 1970, that committee again held hearings on essentially the same proposal submitted by the new administration which comprised 16 volumes and

4,691 pages. Both hearing records have been made available to the Committee on Finance and its staff for study.

Thus, the basic issues raised by the committee's trade amendment to the Social Security Act are matters which the committee has studied since 1967.

Earlier this year, in executive session the committee members determined that it would be wise and useful to hold a public hearing on the trade matter with as many administration and other witnesses as could be heard in the time available to the committee. These hearings were held on October 9 and 12. While the committee did not have as long a time as it normally might have wished for a major piece of legislation, it did get a fuller understanding of what was in the House-proposed bill and how the administration felt about it, as a result of these hearings. In addition, it heard from some major groups and organizations which were opposed to the legislation as well as from some who favored it. Subsequent to the hearings the committee approved, in executive session, the basic provisions of the House-passed trade bill, as an amendment to the Social Security bill (H.R. 17550).

B. REASONS FOR THE AMENDMENT

There have been significant structural changes in the world economy since the end of World War II. The preponderance of the economic strength of the United States in the early post-World War II period permitted this country to give freely of its economic resources to assist other countries in the free world in rebuilding and developing their war-torn economies. An important part of the foreign economic policy of the United States in that period was the leadership it was able to exert toward a liberalized and expanded system of world commerce.

In the mid-50's, as some of the countries in Europe were considering moving toward economic integration, the United States took further measures to liberalize trade in order that Japan might become a full partner among the trading nations of the world. In the late 50's and early 60's, as some of the countries in Europe took major steps toward economic integration, Congress recognized the need to keep countries looking outward in their trade relations by approving the Trade Expansion Act of 1962.

While successful in terms of completing agreement on significant reductions in tariffs among many of the industrialized countries, the Kennedy Round of trade negotiations had little success in dealing with the problems of barriers to trade other than tariffs. The remaining task of economic integration in Europe and the development of regional trade blocks in other areas of the world blunted the thrust of the Kennedy Round toward further progress in trade liberalization.

During the 1960's, there has been a tremendous growth in productive capacity abroad. What has come to be recognized as an economic miracle in Japan has made that country the third largest industrial nation in the world. Not far behind in economic growth has been the development in Europe and in particular West Germany. Indeed, many of the development goals toward which the United States strived in the early post-World War II period are being realized. While the economies of the developing countries have not kept pace with the progress of the industrialized nations, many of these countries, particularly in the Far East, have developed new and modern in-

dustries. These industries, usually involving mass production techniques imposed on a low-wage base, in some instances an extremely low-wage base, have enabled some of the developing countries to assume a formidable competitive position in world markets.

At the same time as productive and therefore export capacities abroad have been expanding, the United States has continued to experience deficits in its balance of payments. In more recent years, due to a variety of factors, the balance of trade of the United States has also moved to a far less favorable position. One of the developments that has affected the efforts to improve the balance-of-payments position, and has worked to erode the traditional export surplus of the United States has been the pervasive influence of domestic inflation experienced by the United States, particularly since the mid-1960's.

A major factor in the trends in U.S. exports and imports over the past 5 years has been the long-term upward trend in prices, both at the wholesale and at the retail level. Between 1960 and 1969, the U.S. export prices in terms of unit values of manufactured exports increased by 18 percent, a rate of increase greater than that experienced by any other major industrialized country. In comparison, the unit value of manufactured exports from Japan experienced an overall decline during the decade.

Inflation in the United States has not only affected the competitive position of U.S. exporters; it has increased significantly the competitive impact of imports on domestic producers. Other countries facing similar problems have either devalued their currencies (thus making their goods more competitive in world markets) or imposed import restrictions, or a combination of both. The United States has neither devalued its currency nor imposed import restrictions to improve its competitive position or balance of payments. The combination of increased productive capacity abroad and inflation in the United States has resulted in greatly increased imports. The rate of increase in imports in some product areas, if allowed to continue, would call for economic adjustments in the domestic economy which would be as undesirable as they are unacceptable.

The committee believes that the U.S. economy, and the world economy in general, have been well served by the leadership exerted by the United States in expanding world trade. The preponderance of the economic strength of the United States afforded this country the opportunity to exert such leadership in the anticipation that other countries would follow. However, the hope that other countries would move toward allowing greater access to their own markets has not been realized. Certain major trading countries continue to maintain unjustifiable and unreasonable restriction on imports and investment even though they are enjoying strong domestic economies and balance of payment surpluses. To date, there has been precious little evidence that would indicate that these foreign countries are willing to share the burdens of improving the international adjustment process by removing or ameliorating their barriers against U.S. imports.

The stake that this country has in expanded world trade is, of course, still important. But, the time has come for other countries to realize that the United States alone can not accept all of the surplus production stemming from increased productivity abroad. Other industrialized countries must move much more rapidly to open their markets,

not only to competitive products of other industrialized countries, but also to the exports of developing countries.

The United States remains the largest and most accessible market in the world. Despite the claims of our trade partners, U.S. duties, subject to continued reductions under the trade agreements program, are at the lowest average level of any major industrialized country. Aside from the agricultural area, in which some restrictions are necessary as a corollary of domestic agricultural policy, the U.S. quantitative restrictions on imports are few. In some cases, such as coffee and sugar, the quantitative restrictions for the most part serve the interests of developing countries in contributing to the stability of their export earnings.

This is in contrast to many other countries which have moved much more slowly in opening their markets. Situations have already arisen which make necessary extraordinary measures by the United States to protect its own producers when foreign markets are closed. The Meat Import Act of 1964 was made necessary primarily because other markets in Europe suddenly closed to the major beef producers in the South West Pacific and caused trade diversion to the United States. Restraints maintained by virtually all the European countries on imports of textiles and apparel from countries in the Far East have added to the great increase in competitive pressures which have been borne by the U.S. textile industry since the late 1950's. Over 50 percent of Japan's apparel exports are destined for the United States, compared with only 5 percent to Europe. The Secretary of Commerce presented the committee with a voluminous list of such restrictions, which are published in the hearings record. It is unfortunate that since the Trade Expansion Act of 1962, foreign nontariff barriers have grown, not diminished, particularly in the agricultural field, and in border tax adjustments. Moreover, soon after the Kennedy Round was completed many foreign countries devalued their currencies or took other measures which in effect, vitiated all or part of their tariff concessions granted during the Kennedy Round.

Trade policy requires continuing adjustments as economic conditions change. However, as expanding world trade calls for economic adjustments in a nation's economy, dynamic developments in the world economy sometimes necessitate temporary measures to avoid uneconomic and unwarranted adjustments. Also, the nontariff import barriers and export subsidies of other nations have added to the competitive difficulties of U.S. firms.

Since the end of the Kennedy Round, it has become obvious that the remedial provisions in domestic trade law have not afforded domestic producers adequate opportunity to adjust to competitive forces, particularly during an inflationary period. For these reasons, the committee has provided measures that will afford domestic producers the time and opportunity to adjust to new competitive situations. The committee's amendment also strengthens the unfair trade practice statutes to enable domestic industries, firms, and workers to obtain prompt relief against unwarranted and unjustifiable foreign trade practices.

The changes made in the tariff adjustment and adjustment assistance provisions recognize the adjustment process which must be followed if the United States is to continue an overall policy of liberal trade. Insofar as textiles and footwear are concerned, the

committee believes that the temporary measures for providing quantitative limitations on imports of these articles are absolutely necessary and to ensure the viability of these basic industries, the existence of the companies in those industries, and the livelihood of over 2½ million workers those industries represent. The record is replete with detailed evidence of foreign restrictions in the field of textiles and footwear trade which has served to channel low-cost imports into the U.S. market. The European countries and Japan have import quotas and other restrictions on imports of textile, apparel, and footwear products.

In the past 5 years the ratio of imports of footwear to domestic consumption has increased from 13 to 26 percent and in the first 4 months of 1970, imports were accounting for one-third of the domestic consumption of footwear. If these trends were to continue, imports of footwear would constitute close to 70 percent of U.S. consumption of shoes by 1975. Stated in different terms, in the past 5 years imports of footwear more than doubled from 96 million pairs in 1965 to 202 million pairs in 1969. Imports thus far in 1970 were running at an annual rate of 282 million, three times the volume of imports in 1965.

Domestic production of footwear declined from 642 million pairs in 1968 to 581 million pairs in 1969. The annual rate of production thus far in 1970 is about the same as for 1969.

The rapidity of and the magnitude of increases in imports of footwear in recent years cannot be sustained if this country is to have a viable footwear industry. Unless and until firm measures are taken to arrest the sharp decline in the share of the domestic market available to domestic producers, there will continue to be a contraction in domestic production.

Job losses have been experienced in this industry for a number of years. The workers in the industry, and the communities throughout the Nation, who are dependent upon the shoe industry for their economic support, can ill-afford to suffer further economic dislocation, and what is worse the threat of ever greater loss of sales to imports. The temporary measures provided in the bill to limit the volume of injurious imports, either through quotas or agreements is essential. Such import restraint will remove a serious threat and permit time to adjust. Moreover, the various programs recently proposed by the President for firms producing footwear and their employees can help to revitalize the industry and hasten the removal of the extraordinary relief provided in the bill.

The imports of textiles have constituted a difficult trade problem for a number of years. The potentials of exporting textiles and apparel to the United States and the relative accessibility of this market resulted in the international arrangement for trade in cotton textiles in the early 1960's. As productive capacity developed abroad, exports shifted from cotton textiles, to exports of manmade fiber textiles. Between 1965 and 1969, U.S. imports of textiles of manmade fiber increased from 79 million pounds to 257 million pounds, over a threefold increase. U.S. imports of wearing apparel of manmade fiber increased from 31 million pounds (raw-fiber equivalent) in 1965 to 144 million pounds (raw-fiber equivalent) in 1969. The rate of increase in many product lines has been much more rapid.

For example, imports of sweaters of manmade fibers in 1965 were 501,000 dozen. By 1969 imports of such sweaters had increased to 6,974,000 dozen.

Such increases in imports, year after year, particularly in certain products where imports are gaining a greater and greater share of the domestic market have had a serious impact on textile and apparel firms. The ability of foreign producers to shift product lines and to produce at short notice, large volumes of stylized merchandise at extremely low delivered cost, is beginning to result in an increase in plant closings. Thus, as a result, employment in both textile mills and apparel factories declined by 69,000 in the first 6 months of 1970, the first such decline in a number of years.

Given the great growth in plant capacity abroad, and taking into account plans for even greater production levels in a number of foreign countries the threat to the textile and apparel industry is extremely serious.

The lack of success in gaining the cooperation of textile exporting nations to restrain their exports to the United States of textiles of wool and of manmade fiber at reasonable levels is a cause of great concern to the committee. The problem of world trade in textiles is recognized by all concerned. Unfortunately, the ease of access to the U.S. markets, compared with the restraints on exports of textiles to other developed countries have placed the burden of action on the United States. For example, the United States imports over 50 percent of Japanese apparel exports; the European Community imports only 5 percent.

The importance of the textile and apparel industry and its over 2 million workers to the economy of this country is too great to permit further stalemate or further erosion of the industry's base. In this connection, it should be noted that the industry is playing a vital social role as a growing employer of Negroes, with over 14 percent of the total textile work force being Negro, a higher percentage than for manufacturing industry as a whole. A considerable number of other employees in the textile and apparel industries, particularly in large urban cities are from other minority groups. The threat of import increases in some product lines spreading to all product lines makes industrywide action essential if these jobs are to be saved. Here, too, it is hoped that the measures provided in the bill will prove to be needed only temporarily.

There has been a tendency in the past to administer the Anti-dumping Act or countervailing duty provision as another facet of the trade agreements program under which proposed actions by the United States are negotiable. These provisions of law need to be enforced if domestic producers are to be assured that they may compete with imports on the same basis and subject to the same requirements which domestic producers must meet under provisions of law covering business operations in this country. To this end, the committee believes that many of the changes made both in the trade agreement provisions and other domestic laws are necessary to restore confidence on the part of the U.S. business, that it can expect effective action by the U.S. government in order to protect its interests and the interests of the country as a whole in carrying out the laws as intended by the Congress.

The committee is concerned with developments that erode the productive base of our economy. There are a number of reasons why American firms have established plants abroad among them being the lower wage costs associated with foreign production. It is necessary to face up frankly to the fact that unit wage-cost differentials can and do

bear more heavily on U.S. producers and their workers than ever before due to the economic development abroad in particular industries. With international mobility of capital, management skills, and technological know how, large U.S. industries can move abroad to establish plants, but U.S. labor often cannot, and therefore must bear the brunt of dislocation. As indicated above, the United States cannot accept increases in imports that result in economic adjustments, the costs of which are greater than the benefits derived from increased trade.

U.S. BALANCE OF TRADE AND BALANCE OF PAYMENTS

In the 10-year period 1960 through 1969, our balance of payments has been in deficit in all but 1 year on a liquidity basis and in seven out of the 10 years on an official settlements basis.¹

The cumulative deficits on a liquidity basis of measurement over this period have totaled \$27.2 billion. The deficits generally decreased somewhat in the period 1960 through 1966. For example, as is shown in table 1 over these years on a liquidity basis, the deficit shrank from \$3.9 billion to \$1.4 billion, while on an official settlements basis, a \$3.4 billion deficit was converted to a \$266 million surplus. Since 1966, however, the balance of payments on a liquidity basis has deteriorated markedly, and in 1969, the deficit on this basis exceeded \$7.2 billion. For the first half of 1970, the seasonally adjusted deficit in the balance of payments, including receipts of special drawing rights, was running at an annual rate of \$5.6 billion on a liquidity basis and \$9.2 billion on an official settlements basis.

Our balance-of-payments position would have deteriorated much more rapidly in the past few years than it did were it not for the fact that high domestic interest rates and a shortage of investment funds in the United States attracted a high inflow of short-term money from abroad. Unfortunately, these "tight money" policies have also contributed to the economic slowdown and increased unemployment. Foreign capital inflow in 1960, for example, amounted to \$419 million. By 1966, these inflows had grown to almost \$3 billion and by 1967 to \$3.4 billion. In 1968 they reached the unprecedented level of \$9 billion. By 1969, they still amounted to \$4.1 billion. This influx of foreign funds, however, cannot be expected to continue indefinitely. In fact, in 1970, there has already been some reversal of this pattern and withdrawal of capital funds from this country. This has contributed to the sizable deficit in our external accounts in the early months of this year. This country needs a real surplus on current account—mainly trade—of between \$5 and \$8 billion if it is to offset its capital expenditures for foreign aid, military expenditures abroad and foreign investment.

The United States officially published foreign trade statistics consistently overstate this country's real competitive position. Traditionally, our exports have been tabulated to include U.S. Government concessional sales and outright grants to foreign countries under AID and P.L. 480 programs. This practice overstates our export income since for the great majority of these exports the United States does not earn any hard currencies. The committee feels strongly that

¹ The liquidity balance reflects changes in U.S. reserves and in all foreign holdings (both official and non-official) of liquid dollar liabilities which mature in 1 year or less. The official settlements basis reflects changes in U.S. reserves and in foreign official holdings of both liquid and nonliquid dollar liabilities.

TABLE 1.—U.S. BALANCE OF PAYMENTS, 1960-69

(In millions of dollars)

	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Merchandise trade 1.....	4,906	5,588	4,561	5,241	6,831	4,951	3,926	3,860	624	638
Exports.....	19,650	20,107	20,779	22,252	25,478	26,447	29,389	30,681	33,588	36,473
Imports.....	-14,744	-14,519	-16,218	-17,011	-18,647	-21,496	-25,453	-26,821	-32,954	-35,835
Travel (including fares).....	-1,238	-1,235	-1,444	-1,596	-1,499	-1,613	-1,627	-2,144	-1,872	-2,092
Receipts.....	1,025	1,057	1,070	1,133	1,357	1,545	1,785	1,881	2,035	2,363
Payments.....	-2,263	-2,292	-2,514	-2,729	-2,856	-3,158	-3,412	-4,025	-3,907	-4,445
Military.....	-2,752	-2,596	-2,449	-2,304	-2,133	-2,122	-2,935	-3,138	-3,140	-3,355
Receipts.....	335	402	656	657	747	830	829	1,240	1,395	1,515
Payments.....	-3,087	-2,998	-3,105	-2,961	-2,880	-2,952	-3,764	-4,378	-4,535	-4,850
Dividends and interest.....	2,689	3,398	3,883	3,984	4,686	5,088	5,140	5,646	6,000	5,744
Receipts.....	3,752	4,405	4,999	5,309	6,142	6,817	7,282	8,008	8,933	10,207
Payments.....	-1,063	-1,007	-1,110	-1,325	-1,456	-1,729	-2,142	-2,362	-2,933	-4,463
Other services and transfers, including Government grants.....	-1,730	-2,020	-2,023	-2,058	-2,003	-1,941	-2,011	-1,981	-1,947	-1,841
Current account total 2.....	1,873	3,136	2,536	3,269	5,883	4,364	2,492	2,243	-336	-885
Direct investment.....	-1,674	-1,598	-1,654	-1,976	-2,328	-3,468	-3,631	-3,137	-3,209	-3,070
Bank claims.....	-1,148	-1,261	-450	-1,536	-2,465	93	253	-475	253	-541
Nonbank claims.....	-394	-558	-354	158	-1,108	-340	-760	-269	-1,202	-269
U.S. transactions in foreign securities.....	-662	-762	-969	-1,105	-677	-759	-481	-1,266	-1,254	-1,494
U.S. Government capital, net excluding un-scheduled repayments.....	-1,158	-1,621	-1,774	-1,987	-1,799	-1,819	-1,963	-2,427	2,537	-2,097
Foreign capital.....	419	1,398	1,707	1,016	812	492	2,961	3,366	8,970	4,060
Errors and omissions.....	-1,156	-1,103	-1,246	-509	-1,118	-576	-514	-1,088	-514	-2,924
Balance on liquidity basis.....	-3,901	-2,371	-2,204	-2,670	-2,800	-1,335	-1,357	-3,544	1,771	-7,221
Balance on official reserve transactions basis.....	-3,403	-1,347	-2,702	-2,011	-1,564	-1,289	266	-3,418	1,641	2,708

Source: Treasury Department.

1 Balance-of-payments basis.

2 Including unilateral transfers.

concessional exports should be excluded from regular government publications on exports and shown in our balance of payments accounts as part of government foreign assistance programs. Similarly, our imports are understated since they are generally valued f.o.b. at the foreign dock. The practice recommended by the United Nations and the International Monetary Fund and adopted by virtually all of our major trading partners and by over 100 countries is to tabulate import statistics on a c.i.f. basis; that is, to include the costs of insurance and freight. For comparability if nothing else this fact would suggest that the United States should tabulate its import statistics to include the cost of insurance and freight. But the committee feels that in addition to the comparability factor the importer must pay the cost of insurance and freight and those costs are often just as important to a domestic manufacturer who must compete with the foreign import as any other factor with the exception of wage rate differentials.

If our balance of trade figures were tabulated in this fashion, then instead of having a \$15.5 billion cumulative surplus for the years 1965-1969, the United States would have had a \$10.6 billion cumulative deficit. (See table 3.)

In short, the committee is convinced that the U.S. trade position is not as favorable as officially published figures now indicate.

Examination of the decline in the merchandise surplus discloses that while exports have increased moderately over the period 1961-69, they have not nearly kept pace with the rapid growth in imports. This can be seen from table 2 which shows the percentage change in merchandise exports, imports, and balance in the period 1961-69. The most striking point shown in the table is the rapid increase in imports beginning in 1965. In that year they increased 15 percent over the prior year and in 1968, they increased 23 percent over the prior year, which resulted in a decline of nearly 84 percent in the balance. In 1969, the rate of increase in imports slowed down appreciably but still kept pace with the increase in exports occurring in that year.

In 1970, based upon experience in the first half, imports are increasing at a rate of somewhat over 9 percent while exports are increasing by over 14 percent. This, however, in no small part is due to the fact that the export level in 1969 was below what otherwise might have been expected because of the dock strikes in that year. Moreover, as a share of world exports, U.S. exports in the first quarter showed a continuation of the long term decline.

Table 2.—Percentage change in merchandise exports, imports, and balance, 1961-69¹

Percentage change in—	1961	1962	1963	1964	1965	1966	1967	1968	1969
Exports—	2.3	3.3	7.1	14.5	3.8	11.1	4.4	9.5	8.6
Imports—	-1.5	11.7	4.9	9.6	15.3	18.5	5.3	22.9	8.6
Balance—	13.9	-18.4	14.9	30.3	-27.5	-20.7	-1.7	-83.8	10.2

¹ From table 1. Percentage change from previous year.

Table 3.—U.S. trade balance, 1960-69

[In billions of dollars]

	Total exports, f.o.b.	Total imports, f.o.b.	Trade balance	AID and Public Law 480, Govern- ment- financed exports	Total exports less AID and Public Law 480, financed exports	Total imports, c.i.f. ¹	Merchandise trade balance
	(A)	(B)	(C=A-B)	(D)	(E=A-D)	(F)	(G=E-F)
1969----	37.3	36.1	+1.2	² 2.0	² 35.3	39.7	-4.4
1968----	34.1	33.2	+ .9	2.2	31.8	36.5	-4.7
1967----	31.0	26.9	+4.1	2.5	28.5	29.6	-1.1
1966----	29.5	25.6	+3.9	2.5	27.0	28.2	-1.2
1965----	26.8	21.4	+5.4	2.5	24.3	23.5	+ .8
1964----	25.8	18.7	+7.1	2.7	23.1	20.6	+2.5
1963----	22.5	17.2	+5.3	2.6	19.9	18.9	+1.0
1962----	21.0	16.5	+4.5	2.3	18.7	18.2	+ .5
1961----	20.2	14.8	+5.4	1.9	18.3	16.3	+2.0
1960----	19.6	15.1	+4.5	1.7	17.9	16.6	+1.3

¹ C.i.f. imports are assumed to be 10 percent higher in value than f.o.b. imports in accordance with Tariff Commission study.

² Estimated by Department of Commerce.

Source: U.S. Department of Commerce.

The continuing balance-of-payments deficit has been of major concern to this committee, with regard to trade legislation and also with regard to other legislation with which the committee must deal and in particular, tax legislation which affects the competitive position of domestic producers, both in this market and abroad.

The committee is very much aware that the United States holds a unique position in the field of international financial and monetary policy. The responsibility that this country has in the world at large makes it essential that it have flexibility with regard to its international payments position. The dependence of other countries on a healthy U.S. economy and balance of payments, should motivate them to remove restrictions and end policies which tend to perpetuate their balance-of-payments surpluses.

Since the end of World War II, many countries have found it necessary to resort to quantitative limitations on their imports, or more recently import surcharges, as a means of dealing with particularly serious balance-of-payments difficulties. With one major exception, such trade restrictions imposed for balance-of-payments reasons have been eliminated by the major trading countries. But they have substituted other restrictive measures such as variable import fees and border taxes which are often more trade restrictive than import quotas.

Despite its persistent balance-of-payments difficulties, the United States has chosen not to impose restrictions on imports as a means of relieving pressures stemming from the deficits in the international balance of payments. However, the only provision in the GATT dealing with balance of payments safeguards specifically sanctions the use of quotas. Other countries have used quotas and other import-discouraging devices. The trade problems faced by the United States at this time call for the same degree of international understanding and cooperation by other nations, as the United States manifested

toward them in the period when they had balance of payments difficulties.

Among those actions taken by the European Economic Community which have affected U.S. trade interest is the border tax system and the integration of the value added tax system among the member countries. These adjustments have to some degree negated the concessions granted to their countries in the Kennedy Round. As a result, various proposals have been made aimed at offsetting or reducing the impact of the border tax system. There has been no apparent progress toward a solution of this problem. The basic provisions of the GATT dealing with export subsidies, border taxes and balance of payments must be revised to allow for more flexible remedies for countries suffering from serious balance-of-payments difficulties.

Over the years, the GATT, which was established in the very early postwar years, has dealt primarily with the effects of tariffs on trade. Moreover, as originally drafted, the instrument was oriented toward the conditions of trade as they existed at that time. In the ensuing two decades, the conditions of trade, relative tariffs, the structure of world economies and industries changed markedly and rapidly. Accordingly, the basic provisions of the GATT dealing with non-tariff and other factors affecting world trade (such as the effects of subsidies, border taxes, variable levies, the multinational corporations, disparate labor conditions, market disruption) should—indeed must—be reexamined with a view toward the development of a viable instrumentality to deal with trade problems in the context of the complex conditions of trade as they exist today and promise to confront us in the decade of the 1970s.

The United States, which took a strong initiative in the establishment of the GATT at the end of World War II, should again provide leadership in developing an international accord establishing fair ground rules for governing trade problems.

C. GENERAL DESCRIPTION OF BILL (INCLUDING SPECIFIC LEGISLATIVE INTENT)

TRADE AGREEMENT AUTHORITY

BASIC AUTHORITY TO MODIFY TARIFF AND OTHER IMPORT RESTRICTIONS

(Sec. 301 of the bill)

The authority of the President to enter into trade agreements with foreign countries or instrumentalities thereof would be extended until July 1, 1975 for purposes of compensation only. The President's trade agreement authority expired on July 1, 1967, and would be, reinstated, in a limited way, on the enactment of this amendment.

The President did not request trade agreement authority in order to enter into major trade negotiations. The Executive has not presented any proposals to the Congress or the committee with respect to negotiating with foreign countries on trade barriers with foreign countries which would require a grant of authority by the Congress. It was the expressed intent of the President's Special Trade Representative to use this authority mainly for the payment of compensation in situations in which the United States increased a

duty or imposed a new restriction on a product which was the subject of a tariff concession. Consequently, the committee limited the tariff cutting authority requested by the President to those situations in which compensation is required under international obligations. In addition, it determined that the authority should be granted until July 1, 1975, in order not to jeopardize the granting of tariff adjustment relief to injured industries because of the lack of Presidential authority to reduce tariffs.

Under the bill he is authorized to reduce by 20 percent or by 2 percentage points, the rates of duty which will exist when the final stage of the Kennedy Round reductions is to be made effective on January 1, 1972. This authority is limited to those cases in which the President is required under the tariff adjustment provisions or otherwise to proclaim increased import restrictions on an article covered by concessions granted by the United States in trade agreements.

The committee feels that the Executive may not have exercised its rights under international agreements to demand and receive "compensation" from other countries that have imposed higher tariffs or other import restrictions which are in violation of trade agreement concessions. Consequently, the committee feels that whenever a question of "compensation" arises because of an increase in U.S. duties or other import restrictions, the Executive should study carefully its rights with respect to the affected countries' restrictions, and the degree to which "compensation" has been paid to the United States for these restrictions.

The committee did not renew or extend any of the other authorities to modify tariffs provided in section 202, 211, 212, or 213 of the Trade Expansion Act of 1962.

STAGING REQUIREMENTS

(Sec. 302 of the bill)

This section of the bill is directed to the need to implement in two stages, tariff reductions to be made pursuant to trade agreements. The bill provides that the tariff concessions agreed to under this new authority shall be staged in at least two installments with one year intervening. It also provides that tariff reductions agreed to under the new authority may be combined with any remaining stages of earlier proclamations made pursuant to the Kennedy Round of trade negotiations.

The committee agreed to this arrangement recognizing that Kennedy Round tariff reductions will not be fully implemented until January 1, 1972. In practical effect, the last stage of those concessions is the only one which might be pending at the time of negotiations and implementation of new concessions which may be under the authority of this bill. Further, the committee assumes that the President would not stage any new concession concurrently unless he had previously determined that this could be done without detriment to the U.S. industry producing the article or articles affected by the tariff reduction.

OTHER PRESIDENTIAL AUTHORITY

FOREIGN IMPORT RESTRICTIONS AND DISCRIMINATORY ACTS

(Sec. 303 of the bill)

The bill would amend section 252 of the Trade Expansion Act of 1962 and provide new authority and direction to the President to act against import restrictions or other acts of foreign countries which unjustifiably or unreasonably burden, or discriminate against U.S. commerce.

The bill would amend section 252(a) by removing the word "agricultural" so that the President is directed to take such action as he deems necessary and appropriate when a foreign country unjustifiably restricts "any" U.S. product. Such action under existing provisions of the law might include the imposition of duties or other import restrictions on products of the foreign country imported into the United States.

The committee also proposes to amend section 252(b) of the Trade Expansion Act to direct that the President shall take certain actions whenever a foreign country whose products benefit from U.S. trade agreement concessions provides subsidies or other incentives to its exported products to other foreign markets so that U.S. sales of competitive products to those other markets are unfairly affected thereby. This amendment was recommended by the executive branch and approved by the committee as necessary to protect U.S. commercial interests. The committee believes that the executive branch will use this new authority to fully offset any foreign practices which adversely affects U.S. commerce.

In addition, the committee increased the authority of the President under section 252(b) of the Trade Expansion Act by enabling him to impose duties and other import restrictions whenever such a foreign country is maintaining nontariff restrictions substantially burdening U.S. commerce, engaging in discriminatory acts which unjustifiably restrict U.S. commerce or providing such subsidies or other incentives for its exports.

Section 252(c) would be amended by directing and authorizing the President to take action whenever a foreign country whose products benefit from U.S. trade agreement concessions maintains unreasonable import restrictions which substantially burden U.S. commerce. The President is authorized and directed to impose duties or other import restrictions on the products of such foreign country in such instances as well as suspending or withdrawing trade agreement concessions or refraining from proclaiming benefits to carry out trade agreements with such foreign countries.

The committee determined that since subsections (a) and (b) of section 252 are both directed toward foreign import restrictions and discriminatory acts which are illegal, that the scope of Presidential authority to act to prevent the establishment or obtain the removal of such foreign import restrictions ought to be the same in both subsections. Consequently, a new subparagraph (C) to the latter subsection provides powers equal to that provided in existing (a)(3). Similarly it was deemed desirable that subsection (c)(1) be amended to give the President power to impose duties or other import restric-

tions against the unreasonable, though legal, foreign government practices to which that subsection is directed. Finally, the committee deemed it desirable that the obligatory word "shall" used in both of the two first subsections, with regard to the President's action, should also be used in the third subsection in place of the existing "may."

The committee also provided a clear complaint procedure in section 252 similar, in principle, to the procedures used under some other unfair trade practice statutes, such as antidumping and countervailing duty, and to the statutory procedures under the national security provision. Under the committee amendment an interested party could file a complaint with the Secretary of Commerce concerning a foreign import barrier or export subsidy which he feels is unreasonably and unjustifiably restricting U.S. exports. In accordance with the criteria already spelled out in the statute, the Secretary would then investigate to determine whether or not a foreign barrier or export subsidy is unjustifiably and unreasonably restricting U.S. commerce. The Secretary would have a 3-month time limit within which he must reach a finding. If he reaches an affirmative finding, he would inform the President and publish such finding (and the reasons therefor) in the Federal Register. The reasons for a negative finding would also be published in the Federal Register. Under an affirmative finding the President would have an additional 3 months to work out a solution to the problem through negotiation with the foreign government. If the President failed to obtain a satisfactory negotiated solution, then he would take the retaliatory action called for by section 252.

These amendments provide important new direction and authority to the President to act to protect the interest of United States commerce in the face of unjustifiable import restrictions and other unreasonable import restrictions, including discriminatory acts which substantially burden U.S. commerce or unfairly restrict or affect market access for U.S. products. The committee feels that not only should the President respond to this additional direction by the Congress to protect U.S. commercial interests, it is also incumbent on such domestic producing interests to use the new provisions in section 252(d) to fully and accurately inform the Secretary when action is taken or contemplated by foreign countries in order that the President and those to whom he has delegated this responsibility may act promptly and effectively.

It must be recognized that over the years, the United States has granted increased market access to foreign produced goods in order to gain greater access in foreign markets for goods produced in the United States. It is incumbent on both the government and United States producing interests to cooperate in the maintenance of access to foreign markets on a fair and reasonable basis for goods produced in the United States.

NATIONAL SECURITY PROVISION

(Sec. 304 of the bill)

The committee amendment to section 232 of the Trade Expansion Act of 1962, the "national security provision," would provide that any adjustment of imports under that section shall not be accomplished by the imposition or increase of any duty, or of any fee or

charge having the effect of a duty. The committee has reviewed the legislative history of section 232 of the Trade Expansion Act and its predecessor provisions in the trade agreements legislation, and concludes that the delegation of authority to the President to adjust imports should be limited to the use of quantitative limitations.

The amendment to section 232 is not intended in any way to foreclose the President from adjusting imports to such levels as he deems necessary to prevent impairment to the national security. Nor does it affect the flexibility of the President to modify import limitations already imposed under section 232 to meet increased demands for raw materials or other emergency requirements which may arise from time to time. If, under particular circumstances, not foreseen by your committee, the President believed that duties or tariffs would be a more appropriate remedy in a case he would be free to request such authority from the Congress.

The bill would also amend section 232 with respect to the time within which the Director of the Office of Emergency Preparedness is to make a determination with respect to applications for action under the national security provision. The committee's attention was called to the delays that often ensue in reaching determinations under this section. It therefore has provided that a determination on new applications shall be reached within one year after the date on which the investigation is requested. Determinations on active pending cases are to be made within 60 days of the date of enactment of this Act.

The committee was informed by the Director of Emergency Preparedness that imposition of a tariff in the case of oil imports in lieu of a quota would tend to increase consumer prices on petroleum and petroleum products. Moreover, the committee believes that there are serious practical problems in substituting a tariff for a quota in the regulation of oil imports. The volatility of freight rates, the geographic distribution of the world's oil reserves, and various pricing and taxing policies by foreign governments are important factors which would make the substitution of tariffs to regulate oil imports very costly and inefficient. No tariff can be so scientifically set as to reasonably regulate the level of imports in accordance with the needs of national security. The committee felt that whenever a national security matter is concerned, importations of the commodity involved should be set at a level so as to provide a reasonable degree of certainty that they will not impair the national security. This cannot be done effectively by a tariff or duty scheme.

The committee also considered the fact that four U.S. Presidents, two from each major political party (Presidents Eisenhower, Kennedy, Johnson, and Nixon), after careful study of all the military, security, and economic facts available to them, have determined that quantitative controls over oil imports were in the national security interest. The need for establishing a reasonably specific and predictable level of imports was particularly manifest to President Kennedy who issued the Presidential proclamations which established a regional formula for regulating such imports.

TARIFF ADJUSTMENT AND ADJUSTMENT ASSISTANCE

(Subpart 2 of Part A of Title III)

GENERAL

Subpart 2 of part A of title III of the bill would amend the provisions of title III of the Trade Expansion Act of 1962 (TEA) relating to tariff adjustment for industries, and adjustment assistance for firms and workers. The primary purpose of the amendments is to liberalize the criteria that must be met before such relief may be afforded. Subpart 2 would also make certain other changes in related provisions of sections 311, 317, 323, 326, 351, and 352 of title III of the TEA.

Since the liberalization of criteria and the investigative procedures differ with respect to industry relief as distinguished from firm or worker relief, the two categories will be discussed separately.

TARIFF ADJUSTMENT ¹

Sections 301, 302, 351, and 352 of the TEA set forth the current authority and procedures for an industry to obtain assistance in the form of proclaimed increases in the duty or other import restrictions applicable to articles on which concessions have been granted in trade agreements. Provision is also made therein (section 302) for such industry relief to be provided in combination with adjustment assistance to firms and workers, the terms of which are discussed in the next section of this report relating to adjustment assistance.

The amendment would not change the status of petitioners for tariff adjustment. In other words, section 301(a)(1) would still permit petitions to be filed with the Tariff Commission by any trade association, firm, certified or recognized union, or other representative of industry so long as petitioner's authority is drawn from firms or groups of workers embracing a substantial part of the industry involved.

AUTHORITY FOR TARIFF ADJUSTMENT

(Sec. 311 of the bill)

Section 311 of the amendment would amend section 301(b) of the TEA in a number of significant ways, viz.: (1) By liberalizing existing criteria for tariff adjustment; (2) by adding an additional determination as to the nature of the injury; (3) by including a definition of the term "domestic industry producing articles like or directly competitive with the imported article"; and (4) by directing the Tariff Commission also to investigate factors which in its judgment may be contributing to increased imports of the article under investigation, and (5) by changing the voting requirements of the Commission in regard to its determinations with respect to tariff adjustment remedies.

Relaxed criteria. The amendment would accomplish liberalization of present tariff adjustment criteria basically by (a) significantly modifying the present causal connection between increased imports and trade-agreement concessions, and (b) by substituting for the present concept of "the major factor" (in existing paragraph (3)) the concept

¹ The term "tariff adjustment", as used in the TEA, refers not only to tariff rate increases but also to other import restrictions.

of increased imports contributing substantially toward causing serious injury which was embodied in section 7 of the Trade Agreements Extension Act of 1951, as amended.

The committee relaxed the causal relationship that exists in the Trade Expansion Act between increased imports and trade concessions. Under present law the Tariff Commission must determine "whether as a result *in major part* of concessions granted under trade agreements, an article is being imported into the United States in such increased quantities as to cause, or threaten to cause, serious injury to the domestic industry producing an article which is like or directly competitive with the imported article."

The committee agreed that this "major part" test is too rigid, and adopted the same causal relationship between increased imports and tariff concessions which existed between 1951 and 1962 under section 7 of the Trade Agreements Extension Act, as amended, which in pertinent part, reads as follows:

The Tariff Commission shall . . . determine whether any product upon which a concession has been granted under a trade agreement is, as a result, in whole or in part, of the duty or other customs treatment reflecting such concession, being imported into the United States in such increased quantities, either actual or relative, as to cause or threaten serious injury to the domestic industry producing like or directly competitive products."

The committee determined that restoration of this causal relationship should not impede any industry from receiving relief if it is seriously injured by imports. Restoration of the causal relationship was considered necessary for two basic reasons:

- (1) Without any relationship between increased imports and a tariff concession, the articles imported from Communist countries (which have never received a U.S. tariff concession) would have to be subject to "escape clause" proceedings along with the articles from column 1 or non-Communist countries; and
- (2) Without any causal relationship between increased imports and tariff concessions the United States could be in violation of trade agreement obligations which could give foreign countries a reason for arguing that any action by the United States under tariff adjustment provisions of this act was, *ipso facto*, in violation of such obligations.

With respect to the products of Communist countries, it is entirely conceivable that certain imported products from these countries could be of sufficient magnitude to "tip the scales" in the judgment of the Tariff Commission to decide a case in favor of an affirmative finding. Thus higher duties could be imposed on the articles of free-world countries, because of importations from Communist countries.

The committee felt that the causal relationship between increased imports and tariff concessions embodied in section 7 of the Trade Agreements Act of 1951, as amended, which was in effect for 11 years, was not only fully compatible with U.S. obligations, but did not serve as a hindrance for seriously injured domestic industries from receiving an affirmative determination from the Tariff Commission, on the question of serious injury.

The words "in whole or in part, of the duty or other customs treatment reflecting such concessions" which the committee adopted have not in the past been construed by the Tariff Commission as a reason not to proceed to determine whether increased imports have "contributed substantially" toward causing or threatening serious injury to an industry. The committee strongly believes that the Tariff Commission will not close out any case on an article subject to a tariff concession, because of the causal link between increased imports and a tariff concession, which the committee feels is an integral part of our trade agreement program.

Even in cases in which there is a zero rate of duty on an article which has been bound by a tariff concession, the "binding" itself is a significant concession, without which, high duties could be imposed consistent with international obligations which would assuage the growth of imports and thereby relieve a domestic industry. In Tariff Commission Report to the President on escape clause investigation No. 7-90, under section 7 of the 1951 Act relating to binder and baler twines which had been historically free of duty, the Commission said: (p. 52).

By enacting the escape-clause provisions, of which the language here in question is a part, the Congress was in effect declaring that American industry should be protected against serious injury from an increase in imports following the granting of trade-agreement concessions. The possibility that such injury may occur arises from the fact that a concession, whether it be a "modification" or a "binding" of customs treatment, is conceptually merely an undertaking not to impose a more restrictive customs treatment than that specified for the product involved during the life of the trade agreement. Such an undertaking represents a distinct commercial advantage to any country which receives the benefit of the concession, and constitutes a stimulus to exports of the product from these countries. Thus, the escape-clause legislation is, in the final analysis, calculated to remove or mitigate the stimulus to an injurious volume of imports which may result from the customs treatment of the product in question,¹ an objective which can be effectively served only if remedial action is taken with respect to the customs treatment of such imports from all countries which receive the benefit of the undertaking represented by the concession. Accordingly, if a country received the benefit of a trade-agreement concession, its exports of the product involved must be within the reach of the escape-clause remedy.

Thus, in such situations the committee understands and intends that the "binding" itself would satisfy the causal relationship.

Moreover, the words "in part" mean *any* part, *not* the major part, a significant part or any other qualification on the degree of relationship between increased imports and a tariff concession.

It will be observed that under the relaxed criteria it is sufficient that increased imports, which have resulted in whole or in part from trade-agreement concessions, "contribute substantially" (whether or not such increased imports are the major factor or primary factor) toward

¹ This is implicit in the language of the statute itself, which does not purport to be addressed to the concession *per se* but rather to the "duty or other customs treatment reflecting such concession."

causing or threatening to cause injury. The parenthetical language was inserted to contrast the proposed criteria with the existing concept of "the major factor" and the concept of "the primary factor" proposed by the administration, and to show that these latter concepts were not in any sense controlling in the interpretation of the concept adopted by the committee. The committee's acceptance of the criteria of section 7 of the 1951 Extension Act was also based upon the fact that such criteria had previously been determined by the President to be compatible with our international obligations.

The term "like or directly competitive", used in the bill to describe the products of domestic producers that may be adversely affected by imports, was used in the same context in section 7 of the 1951 Extension Act and in section 301 of the Trade Expansion Act. The term was derived from the escape-clause provisions in trade agreements, such as article XIX of the GATT. The words "like" and "directly competitive", as used previously and in this bill, are not to be regarded as synonymous or explanatory of each other, but rather to distinguish between "like" articles and articles which, although not "like", are nevertheless "directly competitive". In such context, "like" articles are those which are substantially identical in inherent or intrinsic characteristics (i.e., materials from which made, appearance, quality, texture, etc.), and "directly competitive" articles are those which, although not substantially identical in their inherent or intrinsic characteristics, are substantially equivalent for commercial purposes, that is, are adapted to the same uses and are essentially interchangeable therefor.

With respect to question of *threat* of injury the committee believes the factual situation necessary to support a finding that an article is being imported in such increased quantities as to "threaten" serious injury to a domestic industry cannot differ greatly from the factual situation necessary to support a finding that the product is being imported in such increased quantities as to "cause" serious injury. Since both a finding of present serious injury and a finding of threatened serious injury must be related to currently increased imports, it necessarily follows that a finding of threatened serious injury must be based upon facts which, applied to the statutory criteria, show that serious injury is about to occur. In other words, the serious injury must be imminent.

Additional determination as to the nature of injury. There are some situations in which injury to industry would be so serious as to be acute or severe, indicating an especially urgent need for *immediate* remedial relief. Furthermore, in such acute or severe injury cases the relief should be adequate to the nature and extent of the injury. Consequently, the committee provided that in situations in which the Tariff Commission finds that the injury to the domestic industry is acute or severe or that imports threaten to acutely or severely injure such industry, the Tariff Commission would so report to the President. In this case, the President shall impose whatever restrictions the Tariff Commission recommends to remedy the severe or acute injury or threat thereof, unless he determines it is not in the national interest.

The committee intends that acute or severe injury is to be construed as a high level of injury well above the threshold of serious injury required for an affirmative injury determination under paragraph (1)

of section 301(b). However, under this criteria an industry would not have to be on its death bed for the injury to be deemed acute or severe. The word "acute" is taken generally to mean "seriously demanding urgent attention," "intensification of need," "sharp" or "pointed," "constituting a crisis." Similarly, the word "severe" means "sharp," "extreme," or "grievous." Analogously, the committee would consider a broken bone in the body to be a serious injury, and if the broken bone were a compound fracture this would be a severe or acute injury. The body as a whole can be relatively healthy even though one of its members is acutely or severely injured. But if no relief is immediately forthcoming to remedy the acute or severe injury, or threat thereof, the body itself will suffer irreparable damage. Thus, it is the committee's intention that in cases where the injury is acute or severe, the remedy is more urgent than in cases where only serious injury has been found, although in the latter cases, it is expected that the President will also weigh heavily the Tariff Commission's recommendation for relief in his decision to impose whatever restrictive action he deems necessary to provide relief.

The committee rejected the arithmetic approach in H.R. 18970 to the question of severe or acute injury because it involved a number of highly complex and untried criteria which not only would have sharply increased the workload of the Tariff Commission but would not have assured any improvement in the qualitative determinations of the degree of injury involved in any particular case. Moreover, this arithmetic test in H.R. 18970 involved computations which were often difficult, if not impossible, to compute. For example, the arithmetic test would have required that the imported articles be sold at prices "substantially below" those prevailing for like and competitive products produced in the United States, and that the unit labor cost attributable to producing the imported article are "substantially below" those attributable to producing like or competitive articles in the United States. The committee was informed that unit labor costs information is not available to the degree envisioned by this legislation, and believes that the question of whether imported prices were "substantially below" those prevailing in the United States is not essential to the question of severe injury. An article could be sold in the United States only slightly below the domestic price but in such volume and in such concentration that the domestic industry, operating on a very slim profit margin, would not be able to compete.

Moreover, the arithmetic determination would have required the Tariff Commission to determine whether domestic production of the like or directly competitive product is declining or is likely to decline so as to substantially affect the ability of domestic producers to continue to produce the like or directly competitive product "at a level of reasonable profit." The committee was informed that it is extremely difficult to determine what "a reasonable level of profit" constitutes in any one particular product line in a multiproduct industry. Current accounting practices do not usually segregate out profitability on a product by product basis. Moreover, profits tend to vary industry by industry in accordance with the degree of competition in the marketplace and the supply and demand relationships for the goods involved as well as with the general state of the economy.

In opting for the qualitative approach to the question of acute or severe injury, the Committee is placing great faith and expectation in

the sound judgment of the members of the Tariff Commission to reach, after consideration of all relevant factors, a degree of consensus on the question of injury consistent with the intention of this Act and with the exercise of such sound judgment. In this connection, the Committee has noted the generally increasing tendency of Commissioners to resort to the use of separate statements of their views when there are no significant differences between them or when the differences, if any, are not apparent. The committee feels that the Commissioners should strive to eliminate this practice. Commissioners should make reasonable efforts to reach a consensus on the main questions of injury and remedy, and, when this is not possible, should present clear majority and minority viewpoints on these principal questions, with any significant differences clearly drawn and explained.

Definition of domestic industry. This definition of domestic industry, which appeared in former section 7 of the 1951 Extension Act, is the so-called segmentation concept. By virtue of this definition, the domestic industry will include the operations of those establishments in which the domestic article in question (i.e., the article which is "like," or "directly competitive with," the imported article, as the case may be) is produced. Where a corporate entity has several establishments (e.g., divisions or plants) in some of which the domestic article in question is not produced, the establishments in which the domestic article is not produced would not be included in the industry. The concern of the Tariff Commission would be with the question of serious injury to the productive resources (e.g., employees, physical facilities, and capital) employed in the establishments in which the article in question is produced. In the case of multiproduct establishments in which productive resources are devoted to producing products A, B, C, and D, of which only product A is suffering from import competition, it is only necessary that the Commission find that the resources engaged in the production product A have been injured. However, the Tariff Commission should take into account other relevant factors including whether there has been a transfer of productive resources from A to B, C, or D for reasons other than the impact of imports. The extent to which the products of a multiproduct establishment can be so separately considered is necessarily affected by the accounting procedures that prevail in a given case and the practicability of distinguishing or separating the operations for each product line.

A reinstatement of the "segmentation principle" in the definition of industry is made more important now because of the growth and proliferation of mergers and conglomerate type industrial enterprises. One or several of these large integrated firms with many lines of production can take a considerable market share in any one article of production. There may be scores of smaller, nonintegrated firms producing like or competitive products and if the economic condition of the whole large, integrated, multiproduct firm had to be weighed on the scale of injury alongside that of the small, nonintegrated firm, the balance would inevitably be tipped against the small producer.

Factors causing increased imports. Subsection (b)(6) will require the Tariff Commission, in the course of any proceeding initiated under paragraph (1), to investigate any factors which may be contributing to

increased imports of the article under investigation. Such factors would include the effect of tariff concessions, foreign wage rates, and also possible dumping, subsidization, or other forms of unfair competition. If the Tariff Commission has reason to believe that increased imports are attributable in part to circumstances which come within the purview of the Antidumping Act, 1921, section 303 or 337 of the Tariff Act of 1930, or other remedial provisions of law, it is directed to promptly notify the appropriate agency and to take such other action as it deems appropriate in connection therewith. There is no intention in this amendment to transfer to the Tariff Commission action responsibility for the implementation of statutory language falling within the purview of other agencies.

This provision is designed to assure that the United States will not needlessly invoke the escape-clause [article XIX of the GATT] and will not become involved in granting compensatory concessions or inviting retaliation in situations where the appropriate remedy may be action under one or more U.S. laws against unfair competition for which action no compensation or retaliation is in order.

Commission voting requirements. In accordance with subsection (b)(4) the remedy determination of a majority of the Commissioners voting for the affirmative injury determination shall be treated as the remedy determination of the Commission.

Ninety-day transition period. The committee provided the Tariff Commission with a period of 90 days after enactment, within which the Commission, acting as expeditiously as possible, will issue new rules and regulations on handling all petitions under its jurisdiction. The committee intends that the Commission will issue these rules and regulations as soon as possible, but no later than 90 days after the enactment of this Act. During that period, no petition may be filed under section 301(a) of the Trade Expansion Act of 1962.

PRESIDENTIAL ACTION WITH RESPECT TO TARIFF ADJUSTMENT

(Sec. 313 of the bill)

The bill would amend section 351 of the TEA to provide that the President shall, upon receipt of an affirmative injury determination, proclaim such import restrictions as he determines to be necessary to prevent or remedy serious injury, unless he determines that it would not be in the national interest.

When the Tariff Commission makes an injury determination and makes the aforementioned additional determination provided for in section 301(b)(5), the President is directed to implement the remedy determination of the Commission unless he determines that such action would not be in the national interest. In situations in which the President rejects the Tariff Commission's remedy under the national interest provision he would be free to provide whatever relief he deems necessary, which is consistent with this Act and the national interest.

The amendment would make no change in the existing provisions for congressional review which applies to those cases where the President does not carry out the remedy determination of the Commission.

REVIEW OF ADJUSTMENT ACTION

The review procedures on outstanding tariff adjustment actions are amended to provide that the Tariff Commission, in its reports on conditions in the industry concerned with the tariff adjustment, will include information on the steps taken by the firms in the industry to compete more effectively with imports.

The reporting requirements regarding such reviews of tariff adjustment actions are also amended to provide that the Tariff Commission will make findings similar to those in an original tariff adjustment investigation if it should determine in an investigation reviewing an outstanding tariff adjustment action that the existing restrictions on imports are insufficient to prevent or remedy serious injury to the domestic industry. Such finding would be in addition to that presently required with regard to the effect of a reduction or elimination of a tariff adjustment action.

ORDERLY MARKETING AGREEMENTS

(Sec. 314 of the bill)

Section 352 of the Trade Expansion Act is amended to provide that the President may negotiate orderly marketing agreements at any time after an affirmative injury determination. Further, the amendment provides that such agreements may replace in whole or in part tariff adjustment actions. Under existing law, the negotiating authority under section 352 is to be used at the conclusion of the Tariff Commission investigation and the agreements are to be a substitute for tariff adjustment action. This provision may serve as a means for the President to avoid imposing mandatory quotas, if a suitable voluntary agreement is reached.

ADJUSTMENT ASSISTANCE

(Sec. 315 of the bill)

Adjustment assistance for firms and workers injured by increased imports is made more readily available under this amendment. The committee believes that the criteria for determination of eligibility of firms and workers to apply for adjustment assistance contained in the Trade Expansion Act of 1962 are too strict. The committee amendment therefore liberalizes these criteria. The amendment also provides that the President, instead of the Tariff Commission, will make the substantive determinations of eligibility.

Under the amendment, firms or workers may petition directly to the President rather than to the Tariff Commission as at present; also, firms and workers may apply directly to the Secretaries of Commerce or Labor, respectively, after Presidential action providing for such requests following a Tariff Commission finding of injury to an entire industry.

The basic formula for the weekly trade readjustment allowance payable to an adversely affected worker is increased in the bill from 65 percent to 75 percent of his average weekly wage or to 75 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during the week. The existing provisions affording training

and other reemployment assistance to adversely affected workers is expanded to include supportive and other services provided for under any Federal law.

The changes in the bill will serve to make adjustment assistance more effective and more readily available to help individual firms or groups of workers cope with the impact of increased import competition.

Direct Petitions. The Trade Expansion Act of 1962 presently provides that petitions for a determination of eligibility to apply for adjustment assistance may be filed with the Tariff Commission by or on behalf of a firm or group of workers. These are petitions for determinations under section 301(c). The committee amendment changes this procedure by requiring that the petitions be filed with the President rather than the Tariff Commission. It is intended that a group of three or more workers in a firm may qualify as a petitioner for adjustment assistance.

The committee believes that affected workers have a responsibility to endeavor to give prompt notice of difficulties by applying for assistance as soon as they become unemployed or are threatened with unemployment. Section 301(a)(2) of the Trade Expansion Act has been amended to provide that petitions filed by or on behalf of a group of workers shall apply only with respect to individuals who are, or who have been within one year before the date of filing of such petition, employed regularly in the firm involved. Individuals who become unemployed or underemployed after the date of the filing of the petition may be eligible to apply under any certification issued if they are members of the group described therein.

The committee has amended the provisions of the existing act with respect to the criteria to be applied in a determination of eligibility to apply for adjustment assistance by a firm or group of workers. It has provided that the President shall determine whether an article like or directly competitive with an article produced by the firm or an appropriate subdivision thereof is being imported in such increased quantities, either actual or relative, so as to contribute substantially toward causing or threatening to cause serious injury to such firm or subdivision or unemployment or underemployment of a significant number or proportion of the workers of a firm or appropriate subdivision thereof.

This amendment eliminates completely the former causal link between the increased imports and a trade agreement concession insofar as adjustment assistance cases are concerned. These cases are substantially different from the tariff adjustment (industry-wide escape clause) cases in that adjustment assistance involves no potential alteration of trade agreement concessions and therefore should not be related at all to such concessions. No obligations exist with respect to Article XIX of GATT with respect to adjustment assistance cases; they do exist with respect to tariff adjustment cases. The Senate amendment also changes the relationship between the increased imports and the injury or unemployment from "the major factor" to "contribute substantially (whether or not such increased imports are the major factor or the primary factor)."

It is intended that an "appropriate subdivision" of a firm shall be that establishment in a multi-establishment firm which produces the domestic article in question. Where the article is produced in a dis-

inct part or section of an establishment (whether the firm has one or more establishments), such part or section may be considered an appropriate subdivision. In the Trade Expansion Act, this concept was confined to groups of workers. This bill would extend the concept to firms as well.

Section 301(c) of the Trade Expansion Act as amended by the committee provides for reports from the Tariff Commission to assist the President in making determinations with respect to petitions filed by firms or groups of workers. The President is to transmit promptly to the Tariff Commission a copy of each petition filed with him by a firm or group of workers and not later than five days thereafter to request the Tariff Commission to conduct an investigation relating to questions of fact relevant to the President's determinations and to make a report of the facts disclosed by such investigation. In his request, the President may specify the particular kinds of data which he deems appropriate. This is not intended, however, to preclude the Tariff Commission from making an investigation of, and including in its report, such additional data as it considers relevant. Upon receipt of the President's request, it is required that the Tariff Commission promptly initiate the investigation and promptly publish notice thereof in the Federal Register.

It is intended that the President, and not the Tariff Commission, shall make the determinations under section 301 (c)(1) and (c)(2) with respect to firms and groups of workers. Accordingly, the Tariff Commission is not to include in its report conclusions, opinions, or judgments which are tantamount to the determinations. Instead, it is to present the facts and in a manner which will render the report useful to the President. It is recognized that the Tariff Commission will have to reach conclusions with respect to such subsidiary questions as what constitutes the firm or an appropriate subdivision thereof, what product is like or directly competitive, and what is the appropriate base period, in order to gather the relevant facts. In any case, however, the President has the final authority to make a decision with respect to any element which enters into the determinations under section 301 (c)(1) and (c)(2), and section 302 (c), (d), and (e).

In the course of any such investigation, the Tariff Commission shall hold a public hearing if requested by the petitioner or any other interested person. However, such a request must be made not later than 10 days after the date of the publication of its notice of the investigation. It is understood that a public hearing may be held in any case on the Tariff Commission's own motion. The report of the Tariff Commission of the facts disclosed by its investigation with respect to a firm or group of workers is to be made at the earliest practicable time, but not later than 60 days after the date on which it receives the request of the President.

After receiving the Commission's report, the President has a maximum of 30 days in which to make his determination as to whether the firm or group of workers is eligible to apply for adjustment assistance. However, within this period he does have the authority to request additional factual information from the Tariff Commission. The Commission is then to furnish the additional information in a supplemental report within 25 days and the President is to make his final determination not later than 15 days after he receives such supplemental report (section 302(c)).

The President is required to publish in the Federal Register a summary of each determination made with respect to a petition for adjustment assistance filed by any firm or group of workers.

For transitional purposes, investigations relating to adjustment assistance under existing section 301(c) in progress immediately before the date of enactment of H.R. 18970 are to be continued as if the investigation had been instituted under the amended section 301(c) and the petition treated as filed as of the date of enactment. Tariff Commission determinations pending before the President on date of enactment are also to be subject to the amended criteria and procedures.

If the President makes an affirmative determination on a petition for adjustment assistance with respect to any firm or group of workers, he shall promptly certify that such firm or group of workers is eligible to apply for adjustment assistance. This certification permits the firm to apply to the Secretary of Commerce and individual workers to apply to the Secretary of Labor to seek the types and amounts of adjustment assistance provided for in Chapters 2 and 3 respectively of Title III of the Trade Expansion Act of 1962. Certifications of groups of workers specify the workers' firm or appropriate subdivision and, under section 302(d) of the Trade Expansion Act, the date on which the unemployment or underemployment began or threatens to begin.

Section 302(e) of the Trade Expansion Act provides that the President shall terminate the effect of any certification of eligibility of a group of workers whenever he determines that separations from the firm or subdivision thereof are no longer attributable to the conditions specified in section 301(c)(2) or section 302(b)(2). Such termination applies only with respect to separations occurring after the termination date specified by the President.

The committee amendment specifically authorizes the President to delegate any of his functions with regard to determinations and certifications of eligibility to apply for adjustment assistance. Authority to issue rules and regulations related to these delegated functions is provided for under section 401(2) of the Trade Expansion Act.

PRESIDENTIAL ACTION WITH RESPECT TO ADJUSTMENT ASSISTANCE

(Sec. 312 of the bill)

Under the current law (Sec. 302(a)), whenever the Tariff Commission reports to the President a finding of serious injury or threat thereof to an industry, the President may take any of several courses of action. He may provide: (a) tariff adjustment on the imported product involved in the investigation; or (b) that the firms in the industry may request the Secretary of Commerce for certifications of eligibility to apply for adjustment assistance; or (c) that the workers in the industry may request the Secretary of Labor for certifications of eligibility to apply for adjustment assistance; or (d) he may take any combination of such actions. No order of priority among these various courses open to the President is established nor is there a requirement that the President must take some action.

We are persuaded that provision for adjustment assistance should not be continued as a discretionary alternative action for the President in place of tariff adjustment action where the Tariff Commission has made an affirmative injury and remedy determination after an

industry investigation. The committee has amended section 302(a) to deal with Presidential actions after receiving a Tariff Commission report containing an affirmative injury determination for an industry. If the President provides tariff adjustment for an industry, he may also provide that its firms or workers (or both) may request the Secretaries of Commerce and Labor, respectively, for certifications of eligibility to apply for adjustment assistance. If the President does not provide tariff adjustment for the industry, he shall provide that both firms and workers may request the respective Secretaries for certifications. Notice must be published in the Federal Register of each such action taken by the President. As amended, section (302(a)) also requires that any request for such a certification must be made to the Secretary concerned within the one-year period (or such longer period as may be specified by the President) after the date on which the notice is published.

There currently are, and may be, outstanding escape clause actions with respect to a few industries under which the President has acted to authorize firms and workers to request certifications of eligibility to apply for adjustment assistance from the Secretary of Commerce or the Secretary of Labor. It is the committee's intention that the provisions of section 302(b) as amended should also apply to requests from individual firms or groups of workers in those few industries which may be pending on date of enactment of this bill or submitted thereafter.

Under section 302(a) a firm or group of workers is not automatically certified as eligible to apply for adjustment assistance. Following Presidential action upon request by a firm in the industry found to be seriously injured or threatened with such injury, the Secretary of Commerce, in effect, must conclude whether the increased imports found by the Tariff Commission to have caused or threatened serious injury to the industry as a whole have also caused serious injury to the individual firm in question. Similarly, upon request by a group of workers in a firm in such industry, the Secretary of Labor must conclude whether the increased imports have caused or threatened unemployment or underemployment to a significant number or proportion of the workers of the firm or an appropriate subdivision thereof. In both situations, under existing provisions of 302(b), the increased imports must have been the major factor in causing or threatening to cause injury or unemployment. Your committee has amended these provisions to conform to the liberalized criteria in amended section 301(c).

This function given to the Secretaries of Commerce and Labor reflects the intention that adjustment assistance is not to be extended to a firm or group of workers which has not satisfied the conditions of eligibility. Under this procedure, these firms and workers are not required to wait upon a Tariff Commission investigation. It is expected that the Secretaries of Commerce and Labor will continue to make full use of Tariff Commission information derived from its investigation of the industry concerned. It is also expected, however, that where relief is warranted it will be given as quickly and as expeditiously as is practicable and that the Secretaries of Commerce and Labor will issue such rules and regulations that will assure prompt and effective relief.

The committee has required with respect to certifications made by the Secretary of Labor under section 302(b) that such certifications shall only apply with respect to individuals who are or who have been employed regularly in the firm involved within one year before the date of the institution of the Tariff Commission investigation relating to the industry. This refers to industry investigations instituted by the Commission whether by petition on behalf of the industry or by request, resolution, or motion, as the case may be, as provided in section 301(b). It is not intended that these certifications be limited to those individuals who are or who have been employed in the firm involved within the one-year period antedating the institution of the Tariff Commission investigation. Individuals who became or will become unemployed or underemployed (or threatened therewith) after the date of the institution of the investigation or after the date of the filing of the request with the Secretary of Labor may be eligible to apply under the certification if they are members of the group described therein.

Assistance for Individual Workers. The committee concurs with the House in making several changes in the adjustment assistance program for workers directed at helping adversely affected workers adjust to the loss of employment and reenter the labor force as rapidly and efficiently as possible. When the worker assistance provisions of the Trade Expansion Act were enacted in 1962, the Congress recognized that the adversely affected workers would frequently need retraining in a new skill. Section 326 of the Act, therefore, now expressly provides that workers are to be afforded, where appropriate, testing, counseling, training, and placement services available under any Federal law. The committee believes that upgrading the skills and educational opportunities of workers displaced by imports should be encouraged by the various agencies of Government having responsibility in this area.

The provisions were enacted at approximately the same time that the Federal Government was launching the first Manpower training programs under the Manpower Development and Training Act. Since that time it has been demonstrated that workers frequently need other services to prepare them effectively for full employment. The Congress recognized this by providing that workers enrolled in various Manpower programs, such as under the Manpower Development and Training Act and the Economic Opportunity Act, could be given what have come to be called "supportive services." (See Manpower Development and Training Act section 202 (j) and (k) and Economic Opportunity Act section 123(a)(6)).

The committee's amendment adds to the second sentence of section 326(a) of the Trade Expansion Act the phrase "supportive and other services." This phrase includes, to the extent provided in Federal law, services such as work orientation, basic education, communication skills, employment skills, minor health services, and other services which are necessary to prepare a worker who is eligible for assistance under the act for full employment in accordance with his capabilities and prospective employment opportunities. It is the committee's intention that the minor health services furnished under this section be limited to those which are necessary to correct a condition that would otherwise prevent a worker from being able to accept a training or employment opportunity.

We also wish to make it clear that the language of section 337 of the existing Trade Expansion Act authorizing appropriations to the Secretary of Labor to enable him to carry out his functions under the act includes the authority to expend the funds appropriated thereunder for all programs that are provided to adversely affected workers under the act, including training and supportive services, and that use of the funds is not limited to payment of the financial allowances to the eligible workers.

The committee also considered the basic formula for the level of weekly trade readjustment allowances as provided in section 323(a)—65 percent of the worker's average weekly wage or 65 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during the week.

We believe that this level of benefits is now inadequate and has increased it to a basic formula level of 75 percent of the worker's average weekly wage or 75 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during the week. If this provision had been in effect in the summer of 1970, the maximum payment would have been \$98 per week.

This increase is based on the policy inherent in the Trade Expansion Act of 1962 that readjustment allowances are intended to do more for adversely affected workers than the compensation provided by unemployment insurance. The level of benefits available under state unemployment insurance has increased appreciably since 1962, and some states now provide unemployment compensation higher than the readjustment allowances established in the Trade Expansion Act of 1962. The President has also recommended that the States take action to assure that unemployment insurance be increased to a maximum representing not less than 66½ percent of the average weekly wage in covered employment.

The increase in trade readjustment allowances recommended by the committee will serve to maintain the general 1962 relationship where such allowances were higher than unemployment compensation. We believe that this relationship is appropriate in view of the fact that the finding that the unemployment was caused by increased imports implies that a lower level of imports would have resulted in full job maintenance. Worker assistance is, therefore, in the nature of adjustment to conditions resulting from actions taken for the benefit of the nation as a whole.

The basic amended formula for the level of trade readjustment allowances will apply for weeks of unemployment beginning on or after the date of enactment of the bill. The amended formula will thus also apply to workers who became eligible through a certification issued before enactment of H.R. 18970.

The committee has maintained the standards of eligibility of the individual to receive adjustment assistance benefits which were established in the Trade Expansion Act of 1962. These standards are stricter than those under State law for eligibility for unemployment insurance or those under the Manpower Development and Training Act. In order to be eligible for assistance the individual worker must be a member of the group specified in the certification and must have been separated from adversely affected employment due to lack of

work. That is, he must have been separated from a firm or subdivision for which a certification of worker eligibility has been issued. The worker must also have had a substantial employment history: he must have been gainfully employed (at weekly wage of \$15 or more) for at least half of the weeks of the three years preceding his separation from adversely affected employment and in the 52 weeks immediately preceding his separation he must have had at least 26 weeks of employment in a firm or firms, the workers of which have been found adversely affected by imports. The committee believes that these stricter standards of individual eligibility are justified by the scale of trade adjustment assistance compared with that available under other programs.

QUOTAS ON TEXTILES AND FOOTWEAR

(Part B of Title III)

Part B of title III provides temporary measures to restrict imports and avoid the threat of serious injury to the textile and footwear industries and further deterioration in the domestic market for textiles and apparel and nonrubber footwear.

This is to be accomplished by—

(a) The establishment of annual quotas, based on imports during 1967–69, by category and by foreign country of production for all categories of textile articles and footwear articles which may be imported during each calendar year beginning after December 31, 1970;

(b) Authorizing exemptions from such quotas when the President determines that exemption will not disrupt the domestic market or that exemption is in the national interest; and

(c) Authorizing negotiation of agreements with foreign countries which would result in the regulation of imports into the United States of textile articles or footwear articles or both and would supersede the statutory quotas for the articles covered by the agreements.

Within this general framework, part B of title III authorizes increased imports where the supply of articles subject to limitation is inadequate to meet domestic demand at reasonable prices; provides for certain exclusions with respect to noncommercial entries and to articles already subject to international agreement; and establishes the applicability of the rulemaking provisions of the Administrative Procedure Act to various actions under part B of title III of the bill. Part B of title III terminates at the close of July 1, 1976, unless extended in whole or in part by the President following his determination that such extension is in the national interest.

These provisions are designed to provide a mechanism for establishing a reasonable and effective limitation on U.S. imports of textile products and of nonrubber footwear products for the broad purpose of remedying market disruption in those cases in which it now exists, and of preventing the spread of market disruption to other categories of articles. It is intended that, insofar as may be possible, the limitation of these imports will be accomplished through the negotiation of voluntary agreements provided for under section 322 and that the quota provisions of section 321 will assist in the negotiation of such agreements as well as to provide protection for the domestic market and workers in cases where such agreements are not concluded.

The quota, exemption, and agreement provisions of part B of title III are intended to assure that all textile articles and all footwear articles, as defined, come within the scope of such provisions and may, at any point in time, be subject to quota or agreement if they are not at such time exempted.

The committee in its deliberations of import controls for textiles gave careful consideration to the relationship of the thousands of textile articles and the devastating effect which results when one textile article is controlled and imports shift to one not under restraints. The committee firmly believes that the only way to effectively control textile imports by means of negotiated agreements is to provide for comprehensive coverage of the textile articles described and defined in part B of Title III. We expect this title to be administered so as to carry out this basic and necessary concept.

ANNUAL QUOTAS

(Sec. 321 of the bill)

Annual quotas are established by statute on the total quantity of each category of textile articles (defined in sec. 326), and of footwear articles (defined in sec. 326), produced in any foreign country which may be imported during 1971 and in each subsequent year. The limit for 1971 for each category of articles produced in each country is the average annual quantity of such articles from such country which was imported during the years 1967, 1968 and 1969.

1. *Selection of Base Level*

Textiles.—The average of imports from all countries of the principal textile articles not at present subject to import limitation (or to voluntary export restraint to the United States), i.e., principally wool and man-made fiber textile articles, amounted to an annual average of 1,390 million square yards equivalent in the 1967–1969 base period for man-mades, and 184.5 million square yards for wool textile products. (These figures include tops, yarns, fabrics, apparel, and made-up and miscellaneous textile products.) In 1969, imports were 1,782.6 million square yards equivalent for man-mades and 191.1 million for wool textiles. As of June 1970 imports are running at an annual and all time record rate of 2.4 billion square yards for man-made fiber textiles. However, wool textile imports are expected to total 150 million square yards.

At the same time, cotton textile imports, which are subject to the terms of the Long Term Arrangement Regarding International Trade in Cotton Textiles, are continuing at a high rate. They are expected to again reach more than 1.6 billion square yards in 1970.

Apparel, the most labor intensive sector of the textile-apparel industry is experiencing a continuing sharp increase in imports. At present rates, 1970 apparel imports will rise to 1.6 billion square yards equivalent, of which more than 1 billion yards will be manufactured from man-made fibers, 500 million will be cotton apparel and 50 million will be wool apparel.

These imports pose a threat to the future of a strong textile-apparel "industry" in the United States and its over 2 million employees unless import growth is more closely brought into balance with growth in the domestic market and in domestic production.

Nonrubber Footwear.—U.S. imports of footwear (non-rubber) have also surged in recent years, from a 1961 level of 40 million pairs to a 1969 level of 202 million pairs. Each recent year has seen a sharp and substantial rise in these imports, from 133 million pairs in 1967, to 181 million in 1968 and to more than 200 million in 1969. 1970 imports are expected to exceed 260 million pairs. At the same time, U.S. production is declining in a number of key lines of products. The decline of employment opportunities for American shoe workers, the closing of shoe factories, and the serious damage done to this industry justify the legislative quotas in the committee amendment.

Accordingly, to relieve the market disruption and the dislocation to firms and workers in these industries, and to restore to them the possibilities for full and equitable participation in future market growth, the 1967–1969 average annual level base formula has been adopted as the base for the statutory quotas.

2. Growth in Base Level Quotas

The quantities provided for under the base level (1967–1969) formula may be increased annually beginning January 1, 1972 by not more than 5 percent of the amount authorized for the preceding calendar year if the President determines that an increase is consistent with the purposes of section 321 (section 321 (b)(1) and (b)(2)(A)). Any percentage increase granted for a category of articles is to be the same for such category from all countries.

Section 321 also provides (subsection (b)(2)) that a yearly determination be made of the quotas which would apply for each category of articles from each country throughout the life of this title III, part B, notwithstanding that such limitations may not, in fact, be in effect as a result of the operation of other provisions of this title (e.g. the exemption authority (sec. 321(d) or the agreements negotiated (sec. 322)). This requirement will assure that a continuing reference point is maintained enabling the comparison of statutory quotas with negotiated agreements and with actual trade which has been permitted to occur as a result of use of the exemption authority by the President.

Section 321(b)(3) provides that when a quota under this section begins or resumes after a period in which the article produced in a foreign country was exempted from quota as a result of a Presidential decision, or an agreement under section 322, and the President determines that imports of such article from such country during the 1967–69 period were insignificant, a more recent base period shall be used with respect to such article from such country if he finds that use of such more recent base period is consistent with the purpose of this section. In that event, the quota for such articles shall be an amount equal to the average annual imports of such article from such country during the three calendar years preceding the year in which the quota goes into effect. Under this provision the President will have flexibility in a case in which a given country's base period trade (i.e., U.S. imports from that country in the 1967–1969 period) was insignificant and the article has been the subject of an exemption by the President under section 321(d) or was exempted under an agreement provided for in section 322 or 324(b).

Section 321(c) further provides for the spacing of allowable annual quotas over the course of a calendar year as appropriate to carry out the purposes of section 321. Such spacing, taking seasonal factors

in trade and production into account, would enable the President to avoid a heavy influx of quota goods in a short period of time at the beginning of a year, an influx which could disrupt the domestic market under some circumstances. Also, by requiring a re-opening of a divided annual quota, importers of smaller volumes of articles would be given several opportunities to participate in the entry of available quota articles. Section 321(c)(2) provides for the pro-rata adjustment of any annual quota which comes into effect after the beginning of a calendar year as the result of the termination of an exemption or other actions authorized by part B of title III. At such time, in addition to the amounts actually entered during the calendar year up to the date the quota resumes, an additional quantity equal to the statutory quota adjusted pro rata according the number of full months remaining in the calendar year after the date of such quota resumption is authorized to be imported.

EXEMPTION OF ARTICLES FROM QUOTAS

(Sec. 321 of the bill)

The bill provides three mechanisms through which textile or footwear articles may be exempted from the quotas imposed under subsections 321 (a), (b), and (c), in the absence of an international agreement concluded under section 322 (or the arrangement or agreement referred to in subsection 324(b)).

1. Non-Disruptive Imports

The President is authorized by section 321(d)(1) to exempt articles produced in any foreign country if he determines that imports of such article produced in such country are not contributing to, causing, or threatening to cause market disruption in the United States. These exemptions, which may be made for an initial one year period, and which may be extended for additional periods not to exceed one year each, and may be terminated by the President at any time upon his finding that the article in question is contributing to, causing, or threatening to cause market disruption in the United States.

In making the determinations under section 321(d)(1) and in making similar determinations under other provisions of part B of title III, the President should consider market conditions in the United States for articles similar to the imported articles in question, taking particular account of the relevant market disruption standards set forth in Annex C of the Long Term Arrangement Regarding International Trade in Cotton Textiles (the arrangement referred to in section 204(b)). These market disruption standards are as follows: "these situations (market disruption) generally contain the following elements in combination:

(i) a sharp and substantial increase or potential increase of imports of particular products from particular sources;

(ii) these products are offered at prices which are substantially below those prevailing for similar goods of comparable quality in the market of the importing country;

(iii) there is serious damage to domestic producers or threat thereof; . . ."

In applying market standards under part B of title III, the President would be expected to consider factors affecting the level of employ-

ment, in the domestic industry, including the number of hours worked per week.

In many instances it is the cumulative effect on the market of articles produced in a number of countries which causes market disruption, although the committee recognizes that in some cases the market for a particular article may be disrupted by imports from one country alone.

The committee understands that disruptive conditions in the market for any product cannot in all cases be precisely measured. Thus, while the above quoted conditions are generally found in a circumstance of market disruption, it is not always the case and in other situations different elements may be considered in determining the state of the domestic market for the articles concerned.

The term "articles" in this provision can be as narrowly defined as the President deems necessary and is not meant to be restricted to the "category" of articles as described in the Tariff Schedules of the United States. This would enable the President to exclude individual "articles" within "categories" of articles from the quota provisions if he found that they were not disrupting the domestic market.

It was brought to the committee's attention that certain articles of athletic footwear imports are selected by athletes because they feel that the design of the shoes, including a close fit and light weight, are particularly suited to their needs as a professional or amateur performer. The shoe is selected by the athlete for its suitability for the particular athletic event involved, and the price is generally higher than that charged for domestically produced athletic shoes of the same type. It is expected that the President would exercise his authority in this kind of a situation.

2. The National Interest

Part B of title III also provides that the President may exempt articles from the quotas when he determines that such action would be "in the national interest" (Sec. 321(d)(2)).

The committee intends that the President have freedom in this regard and understands that he is not expected to indicate what particular reasons may have motivated his determination to act on the basis of the national interest criteria.

3. Supply at Reasonable Prices

The President is also authorized to provide for additional imports in excess of established quotas or in addition to the limitations provided in agreements whenever he finds that the total supply from domestic and foreign sources, of textile articles or footwear articles similar to those subject to limitations under such quotas or agreements will be inadequate to meet demands at reasonable prices. This standard is set forth in Section 323.

The committee believes that in view of the broad flexibility afforded the President to exclude individual articles from the quota provisions, specific legislative exemptions were unwarranted. Consequently, the committee deleted a provision in the House version of the Trade Act of 1970 which would have exempted from the quota provisions on textile articles certain woven fabrics for use only in the manufacture of neckties.

NEGOTIATION OF AGREEMENTS

(Sec. 322 of the bill)

Section 322 provides an alternative to the statutory quota provision of section 321. It authorizes the negotiation of voluntary agreements with the countries exporting textile articles, footwear articles, or both. These agreements would provide for the quantitative limitation by category of the textile articles and/or the footwear articles which these countries may export to the United States during each year of the agreement. Such agreements may be administered on the base of either import controls by the United States or export controls by the country concerned or a combination thereof. Whenever such agreements are in effect, the articles which are included under them are exempted from the quota provision of section 321. Both multilateral agreements and bilateral agreements and arrangements are provided for under section 322 and the President is authorized to issue regulations necessary to carry out such agreements.

Section 322(b) authorizes the President to issue regulations limiting the quantity of articles which may be imported from countries not participating in a multilateral agreement whenever such an agreement is in effect among countries, including the United States, accounting for a significant part of world trade in the article concerned, and such agreement contemplates the establishment of limitations on trade in such articles which are produced in countries which are not participating in such agreement. It is intended in this context that a "significant part of world trade" would be in excess of 50 percent of such world trade in the article concerned. The regulations issued by the President under section 322(b) may not provide for lesser quantities from such countries than would be applicable if the quota provision of section 321 applied to such articles.

A multilateral agreement or arrangement covering wool and/or man-made fiber textile products or footwear products could be implemented under this section with respect to imports from countries which did not participate in such an arrangement. The authority provided in section 322(b) is patterned after that provided under section 204 of the Agricultural Act of 1956, as amended in 1962. Any agreement, whether bilateral or multilateral, would be concluded under the authority of section 322(a); section 322(b) authorizes only the issuance of regulations governing imports from countries not participating in multilateral agreements. Section 322(a) authorizes the issuance of regulations covering imports of articles from countries participating in bilateral or multilateral agreements concluded thereunder.

In determining which articles are exempted from quotas as a result of the conclusion of an agreement under section 322, any article falling under the purview of such agreement, whether or not a specific ceiling or limitation has been established for such article in that agreement, is to be exempted from the quota provision provided that under the agreement a mechanism is established whereby the entry of such article into the United States can be limited. This applies with respect to multilateral as well as bilateral agreements or arrangements. In many U.S. bilateral agreements on cotton textiles, some articles are subject to specific limitation while others are subject to consultation provisions. These latter articles (in a similarly structured agreement

pursuant to which limitation can be established) could be exempted from section 321 quotas.

Section 322(a) refers to agreements "regulating by category the quantities of * * * articles * * * which may be exported to the United States or entered. * * *" Thus, the basic thrust of the agreement must be to provide for a limitation of quantities of goods entering the domestic market, recognizing, however, that not all categories of goods from all countries are causing or threatening disruption of the domestic market, and recognizing that the pattern of such disruptive trade changes. In the case of a multilateral agreement implemented under section 322(b), the regulation of imports will also apply to articles from countries which are not party to such an agreement when the agreement provides a basis upon which imports of such articles from such countries can be controlled.

The amendment provides that negotiated agreements with foreign countries will supersede the quotas that otherwise would be imposed. The existing multilateral cotton textile agreement is specifically given this same treatment by the exclusion of articles subject to it for such time as the United States remains a party to that agreement.

The committee recognizes that substantial administrative discretion is required in order to make possible a negotiation of voluntary agreements among a number of supplying countries. For that reason, the bill does not establish any limitation on the quantities of articles that may be exempted from quotas by reason of their inclusion in a bilateral or multilateral agreement. The direction to the President in this respect is contained in Section 322 which requires that in negotiation of agreements, the President take into account conditions in the U.S. market, the need to avoid disruption of that market, and such other factors as he deems appropriate in the national interest.

ADMINISTRATIVE PROVISIONS

(Sec. 325 of the bill)

Section 325 provides generally for the administration of part B of title III. It incorporates by reference the rulemaking provisions of the Administrative Procedure Act (which has been codified in title 5 of the United States Code) with respect to all actions taken under certain specified provisions. Actions brought under these rulemaking procedures concern increases in the quotas, use of the more recent base quotas for countries whose exports were insignificant during the 1967-1969 base, exemptions and terminations of exemptions on the grounds of market disruption or the lack thereof in accordance with section 321(d)(1), the issuance of regulations affecting trade of non-participating countries (sec. 322(b)), and increases in imports authorized under section 323. Also subject to such rulemaking provisions are the issuance of regulations by the Secretary of Commerce, with respect to the exclusion of certain non-commercial articles, the issuance of determinations by the Secretary of Commerce that certain articles should be included in the definition of textile articles under section 326 notwithstanding that they have been classified elsewhere in the Tariff Schedules, and the determination by the Secretary of Commerce of the category systems for textile articles or footwear articles to be established for the purpose of the administration of part B of title III.

Application of the rulemaking procedures to these actions is intended to provide assurance of opportunity for public comment and notice of actions intended to be taken as well as of those which have been taken, and to provide for public hearings where that is deemed appropriate under the circumstances in accordance with that act (subchapter II of chapter 5 of title 5 U.S.C.).

In addition, the bill requires that all quantitative limitations established under part B of title III whether by statute or by agreement, all exemptions and terminations of exemptions, and all regulations issued to carry out title III be published in the Federal Register. Furthermore, to assure an additional comprehensive source of information regarding the state of quota limitations, exemptions, and limitations established under agreements, all of such information is to be included on a continuing basis as a part of the appendix to the Tariff Schedules of the United States. This publication will also include actions taken pursuant to the Long Term Cotton Textile Arrangement.

The committee believes that the use of these rulemaking and notice procedures will provide a sound basis for the development of an effective public information program regarding the operation of this part B of title III. The committee expects that public hearings will be held in connection with the establishment of the administrative machinery for the quota provisions of part B of title III.

With respect to the appropriate administration of quotas on textiles and footwear products, the committee concurred with the House that the President should be given full flexibility and latitude to develop regulations providing for efficient and fair administration of the quotas. The committee expects that the President will, consistent with efficient administration and to the extent practical, use this authority to provide for administration of these provisions to insure against inequitable sharing of imports by a relatively small number of the larger importers. Additionally, if on the basis of the experience with administering these provisions, it is determined that additional legislative authority is required to provide for an efficient and fair administration, it is expected that legislative recommendations will be promptly made to the Congress.

EXCLUSIONS

Section 324 excludes from the import restrictions established in part B of title III certain articles which would be covered by the definitions but which are imported under circumstances which the committee believes should not be subject to quota limitations. The provisions referred to in section 324(a) relate to such circumstances as the importation of personal belongings of persons who have lived overseas, articles brought back to the United States by returning tourists, and similar situations.

The Secretary of Commerce is authorized to issue regulations prescribing the circumstances under which articles imported in non-commercial quantities for noncommercial purposes may be entered free of quota restrictions (sec. 324(a)). In this regard care shall be taken not to exclude from the quotas samples shipments of which are in the nature of commercial sales. The committee intends that such regulations may provide for quota free imports of samples which are not for sale or for use other than as samples, and of other articles imported in very small quantities for personal use. Section

324(b) excludes from Part B of title III all articles subject to the Long Term Cotton Textiles Arrangement so long as the United States is a party thereto. In addition, certain cordage which is subject to a quantitative limitation in the bilateral agreement with the Philippines (the Laurel-Langley Agreement) is exempted for such time as that agreement remains in effect.

Section 324(c) provides that section 22 of the Agricultural Adjustment Act, as amended, is not affected by part B of title III.

DEFINITIONS

(Sec. 326 of the bill)

Section 326 of the bill defines the terms "textile article" and "footwear article" by reference to the applicable provisions of the TSUS.

Except as indicated below, the term "textile article" is limited to any article classified in schedule 3 of the TSUS, if such article is wholly or in part of cotton, wool or other animal hair, human hair, man-made fiber, or any combination or blend thereof, or cordage of hard (leaf) fibers. Specifically excepted from the term, are: raw cotton, cotton wastes and advanced wastes, and cotton processed but not spun; raw wool or hair, wastes and advanced wastes of wool or hair; wastes and advanced wastes of man-made fiber; and scrap cordage and rags. In addition to articles classified under schedule 3, the term includes certain headwear and gloves provided for in schedule 7, parts 1B and 1C of the TSUS, if wholly or in substantial part of cotton, wool, or man-made fiber.

In addition, the Secretary of Commerce is authorized to control under part B of title III of the bill an article which would have been classified under one of the provisions of the Tariff Schedules referred to in section 326(1) but for the inclusion of some substance or because of processing which caused it to be classified elsewhere, in a provision of the Tariff Schedules designed to embrace nontextile articles. The committee intends that this provision be used to prevent or remedy the abuse of the quotas or agreements by avoidance practices which, because of the requirements of Customs laws and interpretations, result in the article being classified as other than a textile article even though it is fundamentally a textile article in use, purpose and design. The committee understands that a possible current example of such avoidance involves the inclusion of a small quantity of asbestos fiber in a fabric made in chief weight of reused or reprocessed wool. It is claimed by importers that this wool should be classified as an article in chief value of asbestos under item 518.21 of the Tariff Schedules. Such a classification, if sustained, would remove the article from the specified coverage of part B of title III as defined in section 321. In such a situation, if the Secretary of Commerce determined that the article is, in a practical commercial sense, a wool textile fabric used interchangeably with articles classified as such by the Bureau of Customs, he could control the article under part B of title III. Prior to making this determination, the Secretary must receive the advice of the Secretary of the Treasury with regard to such classification.

Any article included in the definition, "textile article" which is admitted under item 807.00 of the Tariff Schedules or under the appendix to the Tariff Schedules is also included. Thus, an article

which, if wholly manufactured in a foreign country of foreign materials would be under quota, but which has been manufactured or assembled in part of American fabricated components and which is admitted under item 807.00 is covered by part B of title III. The committee understands that cotton textile articles entered under item 807.00 are currently subject to the LTA and to U.S. bilateral agreements thereunder.

The term category is defined as a group of textile articles or of footwear articles as defined by the Secretary of Commerce using the applicable 5- and 7-digit item numbers of the Tariff Schedules of the United States, Annotated. The committee understands that with respect to textile articles, a category system is in use at the present time as the basis for the compilation of textile trade statistics by the Department of Commerce. The committee understands that this system will be proposed for public comment and that various changes in it may be developed as a result thereof. It is recognized that the development of such a category system can affect trade levels provided for in this title and it is intended by the committee that any changes in such a system will be carefully considered and that the public will have an opportunity to comment on them prior to their adoption. Under this definition, the Secretary of Commerce may revise the category system adopted initially for purposes of part B of title III. The committee intends, however, that such revisions should be made as infrequently as practicable in light of trade conditions, recognizing the value of a continuing and consistent system. The committee notes that the category system used by the United States in its implementation of the Long Term Cotton Textile Arrangement has been revised only once since its original promulgation in 1961.

The term "produced" is defined to mean produced or manufactured, and as such incorporates the standard used in determining the country of origin of an imported article for U.S. customs purposes. Thus, in setting base levels, exemptions, or other controls "by country," part B of title III relies on the existing U.S. customs determinations of country of origin of the articles in question.

TERMINATION

(Sec. 331 of the bill)

Subpart 2 of part B provides that the title will expire at the close of July 1, 1976, unless the President extends it in whole or in part prior to such time.

The President is authorized to make such an extension for additional periods not to exceed more than 5 years at any one time if he determines that such extension is in the national interest. In making such determination, the President shall seek the advice of the Tariff Commission and of the Secretary of Commerce and the Secretary of Labor in addition to such other advice as he may wish to seek. The President is required to report to the Congress with respect to any action taken by him under this provision. Section 331(d) provides that arrangements of agreements included prior to the termination of part B of title III shall remain in effect beyond such termination date if their terms so provide, and that any regulations issued under section 322 in connection with such agreements would similarly remain in effect.

D. ANTIDUMPING AND COUNTERVAILING DUTY PROVISIONS**(Subpart 1 of Part C of Title III)****ANTIDUMPING PROCEDURES****(Sec. 341 of the bill)**

Section 341 of the bill would amend procedures under the Anti-dumping Act to require the Secretary of the Treasury to decide, within four months after a question of dumping is properly raised by or presented to him, whether withholding of appraisement of affected merchandise should be ordered. In exceptional circumstances the Secretary may have an additional period of 90 days if he publishes the reasons for this extra time within 60 days after receiving a complaint. It is intended that this "extra" time would be used by the Secretary only in extraordinary circumstances in which the case is so complex that it would be impossible to make a reasonable determination within only 4 months. The significance of withholding of appraisement is that, if there is later a finding of dumping, the assessment of dumping duties is effective as of the date of withholding. If the Secretary's decision is affirmative, it will be published in the Federal Register and the withholding of appraisement made effective to affected merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication of that notice in the Federal Register.

If the Secretary's decision is negative, it too will be published in the Federal Register. A negative decision in this respect will be accomplished by a tentative determination that the merchandise is not being or likely to be sold below its fair value. The bill provides that, within a period of up to three months after the tentative negative determination is published, the Treasury Department may order the withholding of appraisement if it has reason to believe or suspect that sales below fair value are taking place. Alternatively, the Treasury Department will publish a final negative determination of sales at less than fair value. Under the Treasury's present practice and that contemplated in the future, interested persons are given an opportunity to request an informal hearing on the merits of a withholding of appraisement or a tentative negative determination.

The committee is informed that the Treasury regulations will be amended to provide that the Commissioner of Customs will decide, within 30 days after the information is first received, whether or not a formal investigation regarding alleged dumping should be opened. If he decides that a formal investigation should be opened, he will publish a notice to that effect in the Federal Register. The date of publication will constitute the date on which the question of dumping is raised or presented and trigger the commencement of the four-month period within which the Secretary must decide in the first instance whether or not to order the withholding of appraisement.

The foregoing changes will impose specific time limitations on the Treasury Department within which it must make a decision regarding sales below fair value. This is in sharp contrast with present procedures where such decisions sometimes take two years or even longer.

The committee recognizes that substantial Customs manpower will be needed to carry out the provisions of the committee's amend-

ments. Present preliminary estimates by Treasury call for about 40 more expert technicians, plus additional supporting personnel and the funding required for necessary office space, equipment, allowances for foreign and domestic travel and similar incidental administrative expenses. Moreover, extensive planning will be necessary to permit an orderly implementation of these amendments. For these reasons, your committee has determined that the amendments made by section 341(a) should not be effective until 180 days after the date of enactment of the bill.

The committee feels that these new abbreviated procedures are essential to effectively protect American industry from dumping. Under the current Treasury procedures which make possible long, drawn-out dumping investigations, the affected U.S. industry may be irreparably damaged before the dumping is halted. The committee, therefore, considers it imperative that the time taken by the Treasury in connection with its antidumping investigations be reduced.

At the same time the committee considers it important that procedures not be abbreviated to such a degree that would prevent the Treasury Department from reaching a sound and well-based decision. Deadlines for furnishing information, and rebutting information furnished, whether by American producers, foreign manufacturers or American importers will in many instances create hardships, but nevertheless will have to be adhered to strictly. If the Treasury fails to receive requested information within the prescribed time limits, it will be compelled to act on the basis of the best information available to it. The committee recognizes this as a price that will have to be paid for the changes in antidumping investigation procedures called for in the present bill. It is the opinion of the committee that the abbreviated procedures provided for in the bill represent a reasonable compromise of the interests involved.

Section 341(b) would adopt in the law the substance of the existing Treasury Department practice, as reflected in section 153.3(b) of the Treasury regulations (19 CFR 153.5(b)), under which decisions regarding dumping are made with respect to merchandise from State-controlled economy countries. From time to time, a case arises in which the information indicates that the economy of the country, from which the merchandise is exported, is controlled to an extent that determinations cannot be made in accordance with the usual technical rules. The amendment would confirm the Treasury practice under which the Secretary makes the necessary dumping determinations with respect to State-controlled economy countries based on prices at which such or similar merchandise of a non-State-controlled economy country is sold either for consumption in its home market or to other countries, or based on the constructed value of such or similar merchandise in a non-State-controlled economy country.

The committee also amended section 210 of the Antidumping Act to provide domestic producers with the same rights to judicial review in the Customs Courts that are afforded to importers under existing law.

Importers involved in antidumping proceedings have the right under section 210 to judicial review, in the Customs Court and the Court of Customs and Patent Appeals, of both dumping determinations by the Treasury Department and injury determinations by the Tariff Commission. This right of review has been frequently used by

importers, and in fact the Customs Courts have accepted jurisdiction in a number of cases for review of Treasury Department and Tariff Commission antidumping determinations.

On the other hand, the domestic industries involved in antidumping cases do not have such a clear right to judicial review in the Customs Courts. The law appears to limit such review to importers. Further, the Federal Courts have concluded that they lack jurisdiction to review an antidumping determination by the Secretary of Treasury. *North American Cement Corp. v. Anderson*, 284 F.2d 591 (D.C. Cir. 1960).

In hearings on the International Antidumping Code before the Senate Finance Committee in June 1968, the General Counsel of the Treasury Department and the General Counsel of the Office of the Special Trade Representative suggested that judicial review might be available to domestic industries under the existing law, although this was not clear. In a memorandum submitted by the Executive Branch in connection with the hearings, it was stated that:

It cannot be stated categorically that the Customs Courts would or would not have jurisdiction over actions brought by domestic producers to challenge the consistency of the Code with the Act. As far as we are able to determine, no domestic producer has ever attempted to invoke the jurisdiction of the Customs Court under 19 U.S.C. 1516 in a dumping proceeding. The court, therefore, has never had occasion to pass on the question of jurisdiction.

Absent a decision by the Customs Courts on the issue, however, there is no apparent reason to doubt that the court does have such jurisdiction, bearing in mind the issue of consistency of the Code with the statute would raise questions relating to whether the administrative action was taken within the framework of the statute. Section 210 of the Antidumping Act, 1921, itself appears to provide that the Customs Courts shall have the same jurisdiction, powers, and duties in connection with appeals and protests relating to dumping duties as those courts have in the case of appeals protests relating to customs duties under existing law. And section 516 of the Tariff Act of 1930 (19 U.S.C. 1516) gives domestic producers the right to contest in the Customs Courts administrative decisions relating to appraised value and classification of imported merchandise. (Hearings page 191.)

In any event, it is considered desirable by the committee to clarify that judicial review is available to a domestic industry in an antidumping proceeding. Judicial review is provided to both parties in practically every other statute involving an administrative determination and administrative relief.

COUNTERVAILING DUTY PROCEDURES

(Sec. 342 of the bill)

Section 342 of the bill would amend section 303 of the Tariff Act of 1930 in a number of important respects. Section 303 is the statute under which the Secretary of the Treasury determines whether imported foreign articles receive a "bounty or grant." The Secretary is

required to ascertain and determine, or estimate the net amount of any bounty or grant, and is required to declare the net amounts so determined and order the imposition of countervailing duties.

Although the present statute is mandatory in terms, it does not compel the Secretary to act within any specified period of time. The committee's amendment to the existing law would impose on the Secretary of the Treasury the responsibility to make his determinations as to whether a bounty or grant exists within twelve months after the question is presented to him.

Existing Treasury regulations call for certain types of information to be presented by a person who alleges that an imported article is receiving a bounty or grant. The regulations provide that such communications should include a full statement of the reasons for the belief that a bounty or grant is being paid or bestowed, a detailed description or sample of the merchandise and all pertinent facts obtainable as to any bounty or grant alleged to be paid or bestowed with respect to the merchandise. The regulations go on to provide, among other things, that the Commissioner of Customs will review the information submitted, and if he determines that it is patently in error, he will so advise the person who submitted it and close the case; otherwise he will proceed with an investigation.

The committee is advised by the Treasury Department that its regulations will be amended to require the Commissioner of Customs to determine, within 30 days after the information is first received, whether the information submitted is adequate under the regulations to enable Customs to proceed with the matter. The new regulations will also provide that the person submitting the information will be advised in writing within the 30 days whether or not Customs will proceed with the inquiry. If the information submitted is inadequate, Customs' advice to the person furnishing it will include a statement of the reasons why. The date of affirmative advice would be "the date on which the question is presented" for purposes of triggering the commencement of the 12-month period within which the amendment would require the Secretary to act.

The 12-month limitation would be applicable only with respect to questions presented on and after the date of enactment of the bill. Any inquiries relating to the application of countervailing duties which are already pending in the Treasury Department on the date of the enactment of the bill will not be affected by the 12-month limitation for action. However, the Treasury Department has agreed to make all reasonable efforts to proceed with such inquiries as promptly as possible.

The present statute is mandatory, in that the Secretary is required to apply countervailing duties to *dutiable* merchandise which benefits from a bounty or grant. Section 302(a) would extend the provisions of the statute to nondutiable items. However, in the case of nondutiable items, there will be an additional requirement of a determination by the Tariff Commission that an industry in the United States is being, or is likely to be, injured, or is prevented from being established, as a result of the importations benefiting from the bounty or grant. The Tariff Commission is required under the bill to make an injury determination with respect to nondutiable imports within three months after the initial determination by the Secretary of the Treasury that a bounty or grant is being paid or bestowed. This language con-

ferring jurisdiction on the Tariff Commission was derived verbatim from the Antidumping Act, 1921, and is intended to have the same meaning.

There is no requirement in the existing statute that a U.S. industry be injured as a result of imported foreign merchandise benefiting from a bounty or grant before countervailing duties are to be imposed. The committee determined that there should continue to be no such requirement at this time with respect to *dutiable* imports.

The bill also provides for suspension of liquidation in the event the Secretary of the Treasury determines a bounty or grant exists with respect to nondutiable imports. The suspension would take effect with respect to merchandise entered, or withdrawn from warehouse for consumption, on or after the 30th day after publication in the Federal Register of the Secretary's determination of the existence of a bounty or grant. The significance of this suspension is that if there is later a determination of injury by the Tariff Commission, the subsequent countervailing duty order, requiring the assessment of duties equivalent to the amount of the bounty or grant, issued by the Secretary of the Treasury following the Tariff Commission's determination of injury, would be effective as of the date of suspension of liquidation.

Section 342 of the bill also provides that all determinations by the Secretary with respect to the existence of a bounty or grant and all determinations by the Tariff Commission with respect to injury will be published in the Federal Register. Under the current Treasury practice, countervailing duty orders become effective 30 days after publication in the Customs Bulletin. Accordingly, this new provision will advance by two or three weeks the date orders become effective by avoiding present printing lead time lags in publication of the Customs Bulletin.

As under existing practice countervailing duty orders issued by the Secretary of the Treasury with respect to dutiable items will apply to items entered or withdrawn on or after the 30th day after publication of the Secretary's affirmative determination of the existence of a bounty or grant. Such orders will so apply in the case of nondutiable items if an affirmative determination is made with respect to such items by the Tariff Commission under new section 303(b).

The committee amendment to the existing law would also add a new subsection (d) to section 303 of the Tariff Act having the effect of giving the Secretary of the Treasury some discretion in applying the countervailing duty law to an article which is subject to quota restrictions or to an article whose exportation to the United States is limited by an arrangement or agreement entered by the Government of the United States. The bill provides that no countervailing duty shall be imposed on such an article unless the Secretary determines, after seeking information and advice from such agencies as he may deem appropriate, that such quantitative limitation is not an adequate substitute for the imposition of the countervailing duty.

For purposes of the discretionary authority under the new subsection (d), the Secretary of the Treasury will make his determinations on an article-by-article basis, and not on the basis of overall class. For example, if dairy products as a class are subsidized by a particular country but all products in such class are not subject to U.S. quota restrictions, the discretionary authority under subsection

(d) would be applicable only with respect to the dairy products described in the U.S. quota provisions of part 3 of the appendix to the TSUS. Thus, in the case of a quantitative limitation on a subsidized article which applies only if the price of the article does not exceed a stipulated value, the discretionary authority of the Secretary would not be applicable to imports of such article in cases where the price exceeds the stipulated value.

The committee recognizes that applicability of the countervailing duty law on a mandatory basis to foreign articles benefiting from the payment or bestowal of a bounty or grant by developing countries may present a special problem requiring further consideration. It plans to examine this question at a later date in connection with a general review of problems affecting the developing countries.

The committee is also aware of the Supreme Court cases, and a recent Customs Court case which has interpreted the words "bounty" or "grant" to apply to virtually all subsidies, including the rebate of indirect taxes. The committee has requested in section 361 of this title, a thorough study of the border tax—export rebate system of the European Economic Community with particular reference to U.S. countervailing duty laws.

The committee's amendments preserve the authority of the Secretary to meet situations where the net amount of a bounty or grant changes from time to time. As under present law the Secretary, having once determined that a bounty or grant exists and having declared the net amount of the bounty or grant, will continue to be authorized to order appropriate changes in the net amount, making the changes effective as the facts of the particular case dictate. For example, under present law there is no requirement that changed amounts of bounties or grants be made effective only after a 30-day delay. To the contrary, the changed net amount, whether an increase or decrease, would become effective as of the time the change occurred.

Similarly, in a situation where the Secretary has determined that nondutiable merchandise benefits from a bounty or grant and the Tariff Commission has made an affirmative determination of injury in the case, and countervailing duties are being assessed, if subsequently the amount of the bounty, and therefore the amount of the countervailing duty changes, the Secretary is not required to refer the matter again to the Tariff Commission for a further injury determination. Instead, the countervailing duties may be assessed and collected at the new rate.

The committee has determined that the effective date of the provisions of the bill amending the countervailing duty procedures should be the date of enactment of the bill.

E. TARIFF COMMISSION

(Sec. 351 of the bill)

The Tariff Commission, which was established in 1916, is a permanent independent nonpartisan body whose principal function is to provide technical and fact-finding assistance to the Congress and the President upon the basis of which trade policies may be determined. The committee strongly believes in the need to prevent the Commission from being transformed into a partisan body. For this reason

the committee preserved the present membership of the Commission at six, no more than three of whom can be of any one political party. The committee emphasizes that the Commission and its staff must be selected on the basis of merit. In this connection, the committee calls attention to the provision in section 330(a) that—

No person shall be eligible for appointment as a commissioner unless he is a citizen of the United States and, in the judgment of the President, is possessed of qualifications requisite for developing expert knowledge of tariff problems and efficiency in administering the provisions of Part II of this title.

In addition, the committee finds that it is imperative that measures be taken at once to strengthen the Commission not only in the interest of assuring adequate staff and facilities to handle its current work load which is increasing considerably, but also to prevent its inevitably being overwhelmed by the additional responsibilities imposed upon it by this bill. From testimony received in the public hearings, from discussions in executive session, as well as from other evidence, it is manifestly clear to the committee that, in making policy determinations respecting trade, the Congress and the Executive are far too often severely handicapped by the lack of the requisite relevant background information.

As indicated, the Tariff Commission was created by the Congress, for the very purpose of assisting the Congress and the Executive in their determinations with respect to foreign trade policy. The broad jurisdiction of the Commission in regard to the international trade of the United States is shown by section 332(b), Tariff Act of 1930, which provides—

The Commission shall have power to investigate the tariff relations between the United States and foreign countries, commercial treaties, preferential provisions, economic alliances, the effect of export bounties and preferential transportation rates, the volume of importations compared with domestic production and consumption, and conditions, causes, and effects relating to competition of foreign industries with those of the United States, including dumping and cost of production.

Due to budgetary restrictions over a period of years, the Commission is not adequately staffed or equipped to exercise even in a modest way its statutory investigative powers. The committee notes with concern, for example, that, notwithstanding the fact that trade and trade problems are at a historic high point with resulting increased demands upon the Commission, its staff has been undergoing a systematic attrition by 28 percent since 1966 (from 278 to 200). This staffing contrasts with an average of 315 in the five-year period 1931–35 when imports under the Tariff Act of 1930 were at their lowest point. The consequences of this strict budgetary policy has been low staff morale, loss of staff by resignations and transfers, and extreme difficulties in recruiting. Consequently, the committee amendment identifies the Tariff Commission more closely as a Federal agency independent from the executive departments thus placing its budget authority directly under control of Congress, and removing the possi-

bility of its being reorganized by Executive action. Under the committee amendment there would be no change in the President's authority to appoint Commissioners, by and with the advice and consent of the Senate, in the duties or functions of the Tariff Commission, or in the right of the executive branch or the Congress to call upon the Commission for special studies or investigations. Nor would there be any change in the application of other existing provisions of law, including section 331(b) of the Tariff Act of 1930, which relates to the status of Commission employees under the civil service law.

The committee strongly believes that the only way to preserve the strict "independence" of the Commission from unwarranted interference or influence by the executive branch is to place its budget directly under the control of the Congress. In this regard, the committee had asked the General Accounting Office to study the Tariff Commission. The GAO report indicated that at the very time when its workload was increasing sharply, the Bureau of the Budget was severely cutting back on the Commission's requests to Congress. At the same time, the executive was adding tremendously to the workload of the Commission by requesting long and complex studies. It would appear that the executive branch has placed a low premium on the value of the Tariff Commission in its budget request, but a high premium on the Commission's ability to make the thorough studies and investigations in the face of a cutback in personnel. This appears contradictory.

In the interests of establishing a career-type service for professional employees of the Commission and to enable the Commission to be competitive with other agencies in hiring its staff, the committee is of the view that the Commission should be allocated a reasonable number of super grade positions and should be provided with sufficient funds to the end that the Commission will have adequate staff, grade, structure, and facilities to carry out its assigned duties.

The enactment of the Trade Act of 1970 would add considerably to the Commission's workload. The relaxation of the criteria for tariff adjustment and for adjustment assistance for firms and workers will undoubtedly lead to numerous petitions being filed for investigations by the Tariff Commission. This legislation is expected to greatly increase the Commission's investigative workload and many of its investigations must be performed within strict time deadlines.

The intelligent formulation of trade policy by the executive and the legislative branches is impossible without the development of the factual data on which these policies are based. The Tariff Commission is the agency primarily charged with this responsibility, and with staff expertise and continuity of personnel is ideally suited to do so. Additionally, the Tariff Commission, through its hearing procedures, adjudicates cases of utmost importance to the parties concerned as well as the Nation. Performance of these responsibilities in accordance with the highest professional standards is absolutely essential. The committee therefore strongly emphasizes the need to provide the Tariff Commission with the adequate staff and facilities to meet this high standard.

In connection with its oversight review of U.S. foreign trade policies, the committee's bill directs the Tariff Commission to undertake studies on certain important issues relating to U.S. trade policy. (See Section 362.)

F. STUDIES OF UNITED STATES TRADE POLICIES

COMPREHENSIVE STUDY BY THE PRESIDENT

(Section 361)

There is no statutory recognition of GATT. The Executive never submitted the GATT to the Congress either for its advice and consent or for implementing legislation. United States participation is through the signing in 1947 of the "Protocol of Provisional Application." In trade agreement authorizations the Congress has often put a disclaimer regarding GATT; e.g., "The enactment of this Act shall not be construed to determine or indicate the approval or disapproval by the Congress of Executive Agreement known as the General Agreement on Tariffs and Trade". The United States share of GATT expenses currently comes through the contingency fund of the Department of State.

The committee strongly believes that a direct appropriation for the United States share of GATT expenses sought by the Executive would be a direct recognition of the GATT agreement, including the possible interpretation that in such a recognition, Congress is expressing its approval of GATT provisions and interpretations. Consequently, the Committee deleted a provision from the House version of the Trade Act of 1970 which would have authorized the United States share of GATT expenses.

There are a number of outstanding problems in the field of international trade which require intensive study.

The presently constituted GATT Agreement contains certain provisions that were written in 1947 when the United States had an overwhelmingly dominant position in world trade. Some of these provisions were designed to put dollars into the hands of the then war-torn European countries. In 1947 we had a \$10 billion trade surplus, and \$25 billion in gold with only \$7.6 billion in liquid foreign claims against that gold; in 1970 our trade surplus has virtually disappeared, our gold stock has been reduced to about \$11 billion, and foreigners have \$42 billion in liquid claims against our remaining gold stock. In the light of the changed international economic conditions since 1947 the committee questions whether these provisions offer the United States full reciprocity in international trade. For example, the GATT permission to rebate "indirect" taxes on exports and to apply border taxes on imports in the case of "indirect" taxes, but to deny comparable treatment for "direct" taxes (such as the U.S. income tax) is an example of lack of balance and reciprocity in the agreement.

In addition, the GATT appears to allow European countries to enter into special commercial arrangements with other countries in violation of the most-favored-nation principle. The GATT fails to adequately deal with the question of agricultural trade.

Studies on GATT.—Therefore, the committee requests the Executive to do a thorough study of all GATT provisions by December 31, 1971. Such a study would include, but not be limited to—

(1) The most-favored-nation (MFN) principle and the exceptions thereto; their effect of MFN exceptions on intra-regional and extra-regional trade where common markets and free trade areas are concerned;

(2) The GATT provisions and interpretations on export subsidies and border taxes, the rationale underlying the differing treatment of "direct" and "indirect" taxes insofar as border tax adjustments are concerned, and the U.S. negotiating position on border tax adjustments;

(3) The adequacy of GATT provisions dealing with agriculture;

(4) The adequacy of the balance of payments exceptions in Article XII of GATT;

(5) The GATT provisions on unfair trade practices, fair international labor standards, and relief from injurious imports;

(6) The GATT provisions on "compensation" and "retaliation".

Other Important Trade Issues.—In addition to the above study of GATT provisions the Committee requests a detailed study by the Executive by December 31, 1971, of its plans for negotiating the elimination (or reduction) of foreign nontariff barriers including:

(1) The quantitative restrictions that remain in effect in many countries such as Japan;

(2) The common agricultural policy of the EEC;

(3) The border tax-export rebate system of the EEC, and the reasons why indirect tax rebates on exports are not considered "bounties or grants" within the meaning of the countervailing duty statute as interpreted by Supreme Court cases.²

(4) Discriminatory government procurement policies;

(5) The probable effects of British entry into the Common Market on U.S. trade and balance of payments;

(6) The effect of foreign exchange-rate changes on United States trade and tariff concessions; and

² The case of *Nicholas and Co., v. U.S.* (G. S. Nichols & Co. v. United States 249 U.S. 34 (1919)) represent a landmark decision in the area of countervailing duties. The question in the *Nicholas* case was whether a certain sum of money paid by the British government to its exporters on the exportation of certain British alcoholic spirits amounted to a direct or indirect bounty or grant under the terms of paragraph E of § 4, Tariff Act of 1913.

"The statute was addressed to a condition, and its words must be considered as intending to define it, and all of them—'grant' as well as 'bounty'—must be given effect. If the word 'bounty' has a limited sense, the word 'grant' has not. A word of broader significance than 'grant' could not have been used. Like its synonyms 'give' and 'bestow,' it expresses a concession—the conferring of something by one person upon another. And, if the 'something' be conferred by a country 'upon the exportation of any article or merchandise,' a countervailing duty is required by paragraph E of Section IV of the Tariff Act of 1913."

"We have the fact of spirits able to be sold cheaper in the United States than in the place of their production, and this the result of an act of government because of the destination of the spirits being a foreign market. For that situation Paragraph E was intended to provide." (At pages 39-40.)

In the decision of the Court of Customs Appeals in the same case (*Nicholas & Co., v. United States*, 7 Ct. Cust. Appls. 97), that court, after commenting upon the clarity of the language and purpose of the statute said:

"There is nothing obscure, abstruse, mystic, or even ambiguous about this language, which has been as to the particular words, a part of all our tariff acts from 1897 to and including the present act. Section 5, tariff of 1897 (30 Stat. L., 151), section 6, tariff act of 1909 (36 Stat. L., 11), paragraph E of section 4, tariff act of 1913 (38 Stat. L., 114). Its plain, explicit, and unequivocal purpose is: Whenever a foreign power or dependency or any political subdivision of a government shall give *any aid or advantage* to exporters of goods imported into this country therefrom *whereby they may be sold for less in competition with our domestic goods*, to that extent by this paragraph the duties fixed in the schedule of the act are increased. It was a *result* Congress was seeking to equalize regardless of whatever name or in whatever manner or form or for whatever purpose it was done. The statute interprets itself as a member of an act calculated to maintain an accorded protection. Incidental or otherwise, as against payments or grants of any kind by foreign powers, *resulting* in an equalization thereof to any extent directly or indirectly. Wherefore, in obedience to that obvious purpose, the court does not feel at liberty to adopt any constrained or technical definitions of the words 'bounty' or 'grant' suggested, but to vouchsafe the paragraph a meaning, well within its language, that will best effectuate the unquestioned congressional purpose." (at page 106).

Other Supreme Court decisions have spoken with equal clearness on the subject. The *Downs* case involved a bounty paid upon the exportation of sugar by the Russian government. The court cited examples of what may constitute a bounty within the meaning of the countervailing duty statute:

"A bounty may be direct, as where a certain amount is paid upon the production or exportation of particular articles, of which the Act of Congress of 1980, allowing a bounty upon the production of sugar, and Rev. Stat. sections 3014-3027, allowing a draw-back upon certain articles exported, are examples; or indirect, by the remission of taxes upon the exportation of articles which are subjected to a tax when sold or consumed in the country of their production, of which our laws, permitting distillers of spirits to export the same without payment of an internal revenue tax or other burden, is an example."

Further:

"When a tax is imposed on all sugar produced, but is remitted upon all sugar exported, then, by whatever process, or in whatever manner, or under whatever name it is disguised, it is a bounty upon exportation."

(7) An analysis of whether or not greater flexibility in foreign exchange rates would serve in the interests of United States and world trade;

(8) The nature and extent to which other countries subsidize their exports, directly or indirectly;

(9) A comparative analysis of various proposals to extend tariff preferences to the products of less developed countries with particular emphasis on the effects on U.S. trade and investment patterns and on U.S. labor.

(10) The various agency responsibilities within the executive branch for handling all U.S. foreign trade matters, and the means by which policy coordination is achieved.

TARIFF COMMISSION STUDIES

(Sec. 362 of the bill)

Section 362 of part C of title III requests certain studies by the Tariff Commission by December 31, 1971. These include:

(1) The tariff and nontariff barriers among principal trading nations in the industrialized countries, including an analysis of the disparities in tariff treatment of similar articles of commerce by different countries and the reasons for the disparities;

(2) The nature and extent of the tariff concessions granted in trade agreements and other international agreements to which the United States is a party by the principal trading nations in the industrialized countries;

(3) The customs valuation procedures of foreign countries and those of the United States with a view to developing and suggesting uniform standards of custom valuation which would operate fairly among all classes of shippers in international trade, and the economic effects which would follow if the United States were to adopt such standards of valuation, based on rates of duty which will become effective on January 1, 1972; and

(4) The implications of multinational firms on the patterns of world trade and investment and on United States trade and labor.

G. MISCELLANEOUS AMENDMENTS

(Subpart 4 of Part C of Title III)

AMENDMENTS TO THE AUTOMOTIVE PRODUCTS TRADE ACT OF 1965

(Section 371)

The committee has also amended the special adjustment assistance provisions of section 302 of the Automotive Products Trade Act of 1965. The time for filing petitions under these provisions expired at the close of June 30, 1968. The amendment, in effect, restores, without a specific termination date, the authority for filing petitions by firms and groups of workers for a determination of eligibility to apply for adjustment assistance. These determinations are related to dislocations resulting from the operation of the U.S.-Canadian Automotive Products Agreement.

Special assistance provisions were established in the Automotive Products Trade Act because of the unique characteristics of the U.S.-Canadian Agreement. The agreement required immediate elimination of duties on new vehicles and original equipment parts imported into the United States. It was recognized that dislocations would result not only from increased imports but also from decreased exports, and from shifts in production and supply sources both within each country and between the two countries.

Since the act was passed, trade in automotive equipment has increased markedly and steadily indicating that the process of rationalization of the North American industry was of major magnitude. Adverse employment effects in the United States which may have been attributable to development under the agreement in the first years were largely masked by the general increase in employment in the U.S. automotive products industry, although there were a number of cases where assistance was provided to groups of workers under the transitional adjustment assistance. The authority to petition for such assistance under the act terminated on July 1, 1968. Problems of worker dislocation may continue to arise. On the strength of more than four years of experience during the existence of the U.S.-Canadian Agreement the committee believes that it would be prudent to provide the means of responding to such dislocation.

The committee has also changed the existing standard of "the primary factor" as the required causal link between dislocation and the operation of the agreement to conform to the more liberal standard contained in the Trade Expansion Act as amended by H.R. 18970. The committee has substituted "a substantial factor" in place of "the primary factor" in sections 302 (c), (d), and (g) of the Automotive Products Trade Act of 1965. This new standard will apply to all petitions filed after the date of enactment of this Act including petitions with respect to dislocations which began after June 30, 1968. The committee, however, included a requirement that petitions with respect to dislocations which began after June 30, 1968, and before July 1, 1970, must be filed on or before the 90th day after the date of enactment of this act.

U.S.-Canadian automotive agreement. The committee expects that urgent attention will be given by our Government to the attainment of the agreement's objectives. While our automotive exports to Canada have multiplied, imports have grown even more rapidly, and our bilateral surplus in this sector has disappeared.

The committee has noted that no steps have been taken which will assure attainment of the objective of the agreement of allowing market forces to determine the most economic pattern of investment, production, and trade. For example, although the retail price differential between automobiles in the United States and Canada has been reduced, prices remain higher in Canada. The failure to eliminate the price differential is a consequence of the fact that under terms of the agreement market forces have not yet been allowed to operate freely. In this regard, the committee notes with concern that nearly six years after the agreement was signed the Canadian duty remains virtually unchanged and Canadian citizens still cannot import automobiles duty-free from the United States, although there is no such restriction on imports from Canada. This Canadian restriction and other conditions frustrate the achievement of the free-trade objectives of the

agreement. They artificially permit the continuation of a price differential and interfere with commercial decisions in an industry in which it has been agreed that market forces would be allowed to operate freely.

The Committee noted that in the latest annual report of the President on the operation of the Automotive Products Trade Act of 1965, the President stated:

"Complete realization of the objectives of the Agreement has been impeded by the continued existence of the restrictions to the free flow of trade set forth in Annex A. (This Annex specifies the Canadian duties and other restrictions.) As stated in the Third Annual Report, developments in the trade in automotive products between the two countries indicate these restrictions have served their purpose. Accordingly in 1969 the United States initiated discussions with Canada for the purpose of eliminating the restrictive measures. . . . To date the two governments have been unable to agree on the specific conditions under which the transitional restrictions in Annex A would be eliminated."

The Committee also noted that the U.S. trade balance in automobiles and parts with Canada has deteriorated from a surplus position of \$658 million in 1965 to a deficit of \$686 million in 1969, a deterioration of over \$1 billion since the Agreement was signed nearly six years ago.

Consequently, the committee has added an amendment to the Automotive Products Trade Act of 1965 which provides that the President shall endeavor to secure elimination by the Government of Canada of its duties and other import restrictions on automobiles produced in the United States. If the elimination of such duties and import restrictions has not been secured before January 1, 1973, the President shall consider the failure to secure such elimination grounds (1) for terminating U.S. participation in the agreement and (2) for exercising the authority conferred on him by section 204 of the Automotive Products Trade Act of 1965 to terminate proclamations issued under such act.

RATES OF DUTY ON MINK FURSKINS; REPEAL OF EMBARGO ON CERTAIN FURS

(Sec. 372 of the bill)

Section 372 of the bill establishes separate provisions under which a tariff-rate quota system is imposed on furskins of mink whether or not dressed.

The mink growers have been adversely affected by imports of mink furskins principally from Scandinavia and Canada. At the present time, the demand for mink has declined and domestic production and imports are declining. The number of domestic ranchers is also declining. One of the largest auction houses, that provided substantial assistance to mink ranchers, has recently gone out of business. The serious decline in the domestic industry is a cause for real concern.

Under the Senate amendment the aggregated annual quota quantity is established at 3.6 million skins. This quota quantity is, approximately equal to the volume of skins imported in 1969. The amendment is designed to assist domestic producers in their efforts to rebuild the market for mink.

Imports of mink furskins within the tariff-rate quota quantity will continue to be dutiable at existing rates of duty (a zero rate of duty applies today to raw skins) except that such skins raw or undressed the product of Communist countries will become dutiable at the rate of 30% ad valorem under the Senate amendment. Under the provisions of the House-passed bill, in determining the number of skins and pieces of skins for quota purposes, each of the individual pieces assembled into a plate, mat, lining, strip, cross, or similar form would be counted. The committee found that this would be too restrictive with respect to certain of these plates, etc., made wholly from trimming scrap pieces of mink furskins, and therefore excluded from the tariff-rate quota provisions, trimming scrap pieces of mink, and plates, mats, linings, strip, cross, etc., made from such trimming scrap.

In each calendar quarter when the quota has been filled, mink furskins would become dutiable for the rest of that calendar year at the rate of 25 percent ad valorem if imported from non-Communist countries and at the rate of 40 percent if imported from Communist countries. The bill would make the current rates of duty on certain wearing apparel of mink in schedule 7, part 13, subpart B, of the TSUS permanent rates of duty. Thus, the rates of duty on dressed mink furskins (dyed and not dyed) and on wearing apparel of mink, scheduled to be further reduced during the next two years under the Kennedy Round trade agreement, would be frozen at their present levels.

In agreeing with the House-passed provision which would repeal the existing embargo on certain furs from Russia and China (ermine, fox, Kolinsky, marten, muskrat and weasel), the committee's bill would apply a rate of 30 percent ad valorem to these six furs, when raw and undressed, the product of designated Communist countries. As previously indicated, mink fur skins from such countries would also be dutiable at 30 percent ad valorem as well as being subject to the tariff-rate quota provisions.

RATE OF DUTY ON GLYCINE AND CERTAIN RELATED PRODUCTS (Sec. 373 of the bill)

Section 373 of the bill establishes separate provisions under which a tariff-rate quota system would be imposed on aminoacetic acid (glycine) and salts thereof and certain mixtures of such acid or its salts.

This provision is designed to give special relief to an industry which is adversely affected by persistent dumping practices engaged in by foreign competitors. By reason of such practices, imports increased their penetration of the U.S. market from 25 to 70 percent during the period 1964-67, inclusive. Two of the three domestic producers have stopped production. The cessation of dumping by virtue of action taken under the Antidumping Act, 1921, has provided no relief for the damage already done to domestic producers.

Under the tariff-rate quota system, importers would still be allowed to import at the existing level with no increase in the current rate of duty. Imports in excess of this quantity, however, would be subject to an additional duty of 25 cents per pound. It is expected that this provision would allow domestic producers to recover from the damage

caused by the dumped imports because of the advantage it would give them in producing to meet the increasing demand in the United States for this product.

The rates of duty on both the imports which are within the quota and those which are over-quota would become permanent statutory rates. Thus, they would not be subject to further reductions under the Kennedy Round trade agreement.

PARTS OF SKI BINDINGS

(Sec. 374 of the bill)

Section 374 of the Committee's bill would reduce the statutory duty on parts of ski bindings (TSUS item 734.97) from 11 percent ad valorem to 3 percent ad valorem. This amendment is intended to preserve the competitive position of domestic ski manufacturers who import foreign made parts of ski bindings.

INVOICE INFORMATION

(Sec. 375 of the bill)

The committee is concerned that the official data collected and published with respect to U.S. imports, production, and exports are not adequate to meet the current and expanding needs of U.S. foreign trade policy. Basic to the problem is the fact that the various classification systems under which imports, production, and exports are collected are not generally concordant. These trade data are collected and published by a number of Federal agencies such as the Bureau of the Census, Business and Defense Services Administration, Bureau of International Commerce, Department of Agriculture, Bureau of Mines, Fish and Wildlife Service, Bureau of Customs, and the Tariff Commission.

The committee believes that it is important that the aforementioned trade data be collected and published regularly on a current basis and that they be accurate and in such detail as to be reasonably compatible with their anticipated uses in trade analysis and policy making. With a view to achieving this end, the committee urges each of the responsible government agencies to undertake promptly a review of its statistical programs and to institute at the earliest practicable time, under the coordination and guidance of the Office of Management and Budget, methods specifically for the purpose of establishing compatible classification systems for U.S. imports, production, and exports. It is recognized that the Bureau of the Census, which has primary responsibility for collection and publication of these statistics has for some years been issuing a report on U.S. exports and imports as related to output. This annual publication, however, is far from complete because of lack of comparability of import, production, and export data. Moreover, the publication is not current because of the lag in the availability of production data.

It is understood that methods of improving trade statistics can be developed and implemented without new legislation, except with respect to import statistics which are collected by the Bureau of Customs and reported to the Bureau of the Census for compilation and publication in accordance with the 7-digit statistical import classi-

fications of the Tariff Schedules of the United States Annotated (TSUSA). These 7-digit classifications are established by the Departments of Commerce and Treasury and the Tariff Commission under authority of section 484(e) of the Tariff Act of 1930.

The customs entry form and its supporting invoice, which are filed by the importer or his broker with customs officers at the port of entry, are the basis for all import data collected at the time of entry. Customs officers have traditionally regarded their primary responsibility as being the enforcement of customs laws and the protection of the customs revenue. With the increasing workload and limited staff, the collection of trade data has become a secondary function. As a result import statistics do not receive proper attention from customs officers, foreign exporters, importers, and brokers.

The committee believes that the enforcement of the statistical requirements for imports, as set forth in the statistical headnotes and 7-digit classifications of the TSUSA, is a primary responsibility of customs officers and should be given attention by them accordingly. Such enforcement would be facilitated by the enactment of section 345 of the bill which would amend section 481(a) of the Tariff Act of 1930 to require invoices to provide a product description which would enable customs officers to classify imports for statistical as well as for duty purposes.

The committee recognizes that the provisions of title III of H.R. 17550 will have a significant impact upon the Bureau of Customs, and that substantial additional staffing in customs will be necessary to assure the collection of accurate import trade data.

This new statistical requirement is in no way intended to be an impediment to trade. Rather, it is intended to provide necessary information as to trade that is taking place, to the long run interest of foreign exporting and domestic business, both importer and producer.

It is recognized that the information not previously required will entail some burden on those in the trade, at least initially. In this regard, the importer community can do much to mitigate the initial burden by informing their suppliers abroad of the types of information necessary for the purpose at hand, i.e., information sufficient to classify products according to the TSUSA.

FOREIGN TRADE STATISTICS

(Sec. 376 of the bill)

Current trade statistics tend to distort and mislead the general public and foreign nations as to the true state of the U.S. international economic competitive position. U.S. export data include nonremunerative foreign aid and P.L. 480 sales, and to this extent they overstate our competitive position in world markets. Also, U.S. import data, *unlike* those of over 100 other countries, are tabulated on the basis of their value at the foreign port (free on board or f.o.b.)

The United Nations and the International Monetary Fund recommend that import data for all countries be compiled to include the cost of insurance and freight (cost, insurance and freight or c.i.f. system).

The committee amendment requires the Secretary of Commerce to publish all trade statistics to show with respect to imports: (1) The

value of imported articles in terms of their dutiable value at the foreign port (f.o.b.); and (2) the c.i.f. of such value of imports, including the costs of insurance and freight and all other handling and other costs involved in shipping and importing an article into the customs territory of the United States.

With respect to exports, the Secretary of Commerce shall state separately from the total value of all exports: (1) The value of agricultural commodities under the Agricultural Trade Development and Assistance Act of 1954 as amended; (2) The total amount of all export subsidies paid to exporters by the United States under such Act for the exportation of such commodities; and (3) the value of goods exported under the Foreign Assistance Act of 1961.

Under the Committee amendment, the Secretary of the Treasury would be responsible for collecting all information concerning shipping, insurance and other costs, and forwarding that information on a monthly basis to the Secretary of Commerce, along with the regular f.o.b. value information. The Secretaries of State and Agriculture will also collect export information relating to A.I.D. and P.L. 480 transactions, and will send those data on a monthly basis to the Secretary of Commerce. The Secretary of Commerce will be responsible for the tabulation and publication of those data which would show, with respect to all import data, c.i.f. values along with f.o.b. values, and with respect to export totals, all those exports *not* financed by A.I.D. and P.L. 480 funds and other Government grant programs.

These changes in the method of tabulating U.S. trade statistics will make U.S. trade statistics more comparable with those of foreign countries and will give a more accurate picture of the competitive position of the United States in world trade.

The committee would expect the Secretary of Treasury to fully cooperate with the Secretary of Commerce in gathering the necessary data and making it available to the Department of Commerce.

MEAT IMPORT QUOTAS

(Sec. 377 of the bill)

Section 377 of title III of the bill amends the meat quota provision in Public Law 88-482 to: (1) provide for a quarterly allocation of meat imports and (2) close a loophole in the present law relating to certain "prepared" beef and veal of a fresh, chilled or frozen state.

Quarterly quotas will help avoid the sharp fluctuations in imported meats which, in the past, have disrupted the United States market. These sharp fluctuations have not only disrupted domestic market conditions, but also have worked severe hardship on cattle producers in the major exporting countries. In 1968, 1969, and 1970 heavy meat imports into this country in the early part of the year caused cut-backs in exports by those nations in the latter months of those years. In 1970 the heavy imports of meat into the United States during the early months of the year threatened to exhaust the quota early in the year and served to "trigger" the more restrictive quotas under P.L. 88-482. The quotas were suspended by the President under authority granted to him by P.L. 88-482, and a voluntary restraint system was substituted. The Committee felt that quarterly quotas would have a stabilizing influence on the domestic beef cattle industry as well as on foreign cattle producers who will be able to plan their marketing on an orderly basis.

The committee also included item 107.6020 in the meat import quota provisions. This involves certain "prepared" fresh, chilled or frozen beef and veal, the imports of which during the base period (1959-1963) averaged 1.3 million pounds. It was brought to the committee's attention that earlier in 1970 certain countries began to "prepare" fresh, chilled or frozen beef, by cutting or slicing this meat into pieces, in order to avoid counting these meats against their quota allocations. This avoidance practice threatened to grow to the point where by simple manipulation of meat, an exporting country could have avoided the quotas altogether, unless the practice was stopped.

TRADE WITH FOREIGN COUNTRIES PERMITTING UNCONTROLLED PRODUCTION OF OR TRAFFICKING IN CERTAIN DRUGS

(Sec. 378 of the bill)

Under section 378 the President would be authorized to impose an embargo or suspension of trade with a nation which permits uncontrolled or unregulated production or trafficking in opium, heroin, or other poppy derivatives in a manner to permit these drug items to fall into illicit commerce for ultimate disposition and use in this country.

The committee is greatly concerned that certain countries which commercially produce poppies for pharmaceutical uses, have not adequately controlled, regulated or otherwise policed surplus poppy crops which eventually have fallen into illicit commerce in a derivative form for ultimate disposition and use in the United States.

The language in this provision is designed to give the President the authority to restrain trade with any nation which does not exhibit a willingness to control illegal production or trafficking in opium or heroin. The testimony of John E. Ingersoll, Director, Bureau of Narcotics and Dangerous Drugs, Department of Justice, established that the great preponderance of illicit heroin entering the U.S. results from diversion of Turkish produced opium and its processing into heroin in southern Europe and elsewhere in the Middle East.

We are pleased that on its own initiative, Turkey has set in train a series of actions aimed at minimizing, or eliminating, the harmful effects of Turkish opium in the world. The committee has been advised that by 1971 Turkey will have reduced to four (from 21 in 1967) the number of provinces where farmers may grow opium poppies, and that production will be limited to a more easily controlled area. The committee has also been advised that Turkey is making intensive efforts to keep its opium out of illicit channels, that the amounts should be substantially reduced this year, and that it is in the process of enacting legislation providing for better control.

It is noted that the French Government is also cooperating to bring a halt to the illicit processing and merchandizing of heroin on French territory which eventually finds its way into the United States, creating a drug-abuse problem which is controllable with this kind of cooperation from abroad. The best place to control the critical drug problem in the United States is at the source of supply.

H. PROVISIONS OF HOUSE-PASSED TRADE ACT OF 1970 NOT INCLUDED IN SENATE AMENDMENT

CERTAIN CLASSIFICATION BY THE SECRETARY OF AGRICULTURE

Section 342 of the House version of the Trade Act of 1970 would have provided that the Secretary of Agriculture rather than the Secretary of the Treasury shall have the final administrative responsibility for classifying certain articles subject to import restrictions under Section 22 of the Agricultural Adjustment Act, as amended.

The committee felt that classification of imported materials was properly a function of the Bureau of Customs under the Secretary of the Treasury. Furthermore, the committee was concerned that transferring the jurisdiction for classification of certain agricultural products to the Secretary of Agriculture could lead to demands to transfer jurisdiction for classification of certain industrial products which are under import restrictions to the Secretary of Commerce. The agency administering quotas could be under severe pressure to continually change the import classification system, which could have a deleterious effect on foreign trade.

REPEAL OF THE AMERICAN SELLING PRICE (ASP) SYSTEM OF VALUING CERTAIN IMPORTED ARTICLES

The House version of the Trade Act of 1970 would have authorized the President to proclaim certain modifications in the Tariff Schedules of the United States resulting from two agreements concluded during the Kennedy Round relating to the application of ASP to certain chemicals, canned clams, and wool-knit gloves. Rubber-soled footwear, which is also subject to the ASP system of valuation, would not have been affected by the House provisions.

During the Kennedy Round, the Committee on Finance and the full Senate, concerned that U.S. trade negotiators would exceed the authority granted them by the Trade Expansion Act of 1962, approved a resolution which, in effect, expressed the intent that the U.S. trade negotiators should not exceed the authority granted to the President by the Trade Expansion Act of 1962. Unfortunately, the President's Special Trade Representative did not heed the advice of the Senate with respect to ASP and the International Antidumping Code. The Congress has acted to make those provisions of the International Antidumping Code which conflict with U.S. law, null and void. The committee did not feel that the Senate would be consistent if it approved an ASP agreement which it told the U.S. negotiators not to negotiate in the first place.

Moreover, the committee did not believe that the United States received reciprocity in the ASP negotiation or that the loss of jobs in the benzenoid sector of the chemical industry which would have resulted from the elimination of ASP, would have been offset by gains in employment in other sectors of the chemical industry.

DOMESTIC INTERNATIONAL SALES CORPORATIONS

The House-passed Trade bill (H.R. 18970) contains in title IV provisions relating to a domestic international sales corporation

(DISC) designed to provide United States income tax treatment for export transactions similar to that applicable to profits derived from overseas manufacture.

The basic objective of the provision, as stated by the Administration and in the House Committee report was to eliminate the present disadvantage under Federal income tax law that exists for manufacturing in the United States for export and favors manufacturing abroad. The use of a domestic corporation as a sales subsidiary instead of a foreign corporation was said to simplify administration both for taxpayers and for the Internal Revenue Service, since it would permit books and records to be maintained in the United States in English under our own corporate laws and accounting principles.

Your committee is concerned with the income tax status of American exports as contrasted with that of goods produced abroad by foreign companies, whether or not controlled by Americans. It is also concerned with tax practices in foreign countries giving advantages to their exporters. Your committee is not satisfied, however, that the DISC proposal is the best method of dealing with any imbalance that now exists, and believes that further consideration should be given to the matter at an early date. Your committee is concerned among other matters, with the validity of the present GATT distinction in treatment of direct and indirect taxes on export and imports, and in particular with the present failure to allow any rebates on exports for corporate income taxes paid on export sales profits. The time available since the trade bill was referred to your committee has not permitted the thorough review that it considers essential to a resolution of the issues involved.

Accordingly, your committee has not included in the present bill the DISC provisions of H.R. 18970, but has deferred the subject matter for further consideration early in the next Congress. At that time the Administration and the committee staff will be asked to present studies of various alternative proposals for dealing with the subject and further comments from public witnesses will be solicited.

I. OTHER TRADE MATTERS

There are a number of trade issues on which the committee has no legislative proposal at this time, but on which the committee does have certain views.

U.S. AGRICULTURAL EXPORTS

For some time the committee has been seriously disturbed by the agricultural policies of some of our trading partners. These policies are hurting U.S. farm product exports in two major ways. First, variable levies of the EEC countries are the most protective device ever devised, except for an embargo. They effectively shield the European market from outside competition and, when coupled with high domestic price supports, cause serious disruption of third country markets as well. U.S. exports of agricultural commodities to the European Common Market subject to the variable levy, have declined by 47 percent since 1966. And, surpluses stimulated by high prices in the protected countries are being moved into world trade channels through use of heavy subsidies.

The failure of others to mitigate the impact their agricultural policies are having on the world is a matter of deep concern. U.S. imports of competitive agricultural products over the same period have increased by 15 percent. European Community grain policies have resulted in a drop in European Community net imports from 12 million tons to less than 2 million tons over the last 3 years. This has had significant repercussions on world trade. Moves by the United Kingdom toward increased agricultural protectionism and the prospect of increased reliance on a variable levy system have also contributed to growing world agricultural isolationism. We cannot hope for a better climate until the current trends in agricultural policy are arrested. Specifically, the price of grains in Europe needs to be significantly reduced and subsidies need to be limited. The further extension of restrictionist policies to other products would be very damaging. Any impediment to access for soybeans and soybean products would be of great concern. The committee would expect the President to use every power granted to him by this and other acts, including retaliatory power of section 252 of the Trade Expansion Act to negotiate the reduction and discrimination in the variable levy system.

VOLUNTARY STEEL ARRANGEMENT

Among those industry situations reviewed by the committee in terms of rapidly increasing imports and rising proportion of domestic market accounted for by imports is the position of the domestic steel industry. The attention of the committee has been called to the fact that the voluntary arrangements entered into by the European Coal and Steel Community and Japanese steel producers are to remain in effect until the end of 1971. It is understood that these arrangements provide for annual increases in exports to the United States and involve a commitment to maintain both product and geographic distribution patterns based on trade prior to the undertaking by the foreign steel producers. We believe, based on an extensive staff study of the steel import problem, that this arrangement was necessary to forestall a serious deterioration in the domestic steel market insofar as domestic steel producers are concerned. Accordingly, it is the sentiment of the committee that the administration should endeavor to have these voluntary undertakings extended and improved in order to assure a stable domestic steel industry and an adequate supply of steel for the American economy in the future. It is hoped that the problems of international marketing of steel as recognized by the voluntary arrangement, would also be recognized by the steel industries in countries not party to the agreement, particularly those which export substantial quantities of carbon and specialty steel products to the United States. It is the Committee's view that specialty steels should be included within the terms of these voluntary agreements.

INTERNATIONAL LABOR STANDARDS

The committee is very much aware of the employment problems that can result from economic adjustments created by present trends both in imports into the United States and foreign investment decisions involving shifts of productive capacity abroad.

The huge differentials which exist between U.S. wage costs and those of many other countries pose extremely difficult competitive problems for some domestic industries, as the committee has recognized in the temporary measures provided for in title II with regard to textile and footwear. With widespread availability of technology and capital large differences in labor costs cannot easily be offset by productivity differentials.

The committee has in its amendments of the tariff adjustment provisions also provided means whereby serious injury stemming from such wage differentials can be dealt with on a temporary basis giving time for the adjustment process. For the long run, however, the committee feels that it is in the interest of trade liberalization and expansion that the trade agreements program include formal procedures under which unfair labor conditions can be dealt with.

The committee concurs with the House in the belief that the President as soon as practicable should take steps with respect to trade agreements which would lead to the elimination of unfair labor conditions which substantially disrupt international trade. Machinery should be set up in trade agreements to which the United States is a party which would include: (1) the recognition of principles with respect to earnings, hours, and conditions of employment of workers; (2) the development of a complaint procedure under which situations of unfair labor conditions affecting international trade could be brought before the parties to the agreement for appropriate remedial action; and (3) the establishment of a system of periodic reports by all parties to the agreements on earnings, hours, and conditions of employment for the workers in the exporting industries of the countries involved.

TARIFF DISPARITIES

Tariff rates vary widely from country to country on the same article of commerce. For example, the duty on automobiles in Japan and Canada is 17.5 percent ad valorem; in the European Community, it is 22 percent ad valorem and in the United Kingdom it is about 15 percent ad valorem. The U.S. duty on automobiles is only 4 percent ad valorem.

In many instances, nontariff barriers such as road taxes, border taxes, "uplift" taxes and safety standards clearly add further discrimination against American commerce. The committee has directed the Tariff Commission to do a thorough study on the tariff disparity issue, which would also investigate the tariff and nontariff barriers in each category of articles. The committee feels that the results of this study could lead to negotiating proposals which would aim at greater equality in tariff levels on a product-by-product basis for principal trading nations.

ARTICLES ASSEMBLED ABROAD WITH U.S. COMPONENTS

The committee received a great deal of material with respect to the repeal of item 807.00 of the tariff schedules. During the period 1966 through 1969, the total value of imports under item 807.00 and 806.30, a similar provision which provides for a partial exemption from duty for U.S. articles of metal exported for processing and reimported for further processing, rose from \$953 million to \$1.8 billion. Such a

growth in the use of these tariff provisions is an indication of the economic force at work, particularly with regard to labor costs in labor intensive operations.

The committee recognizes that in some United States firms the provisions, which have the effect of providing a tariff preference for products containing U.S. materials, improve the competitive position of the U.S. firms vis-a-vis products of wholly foreign origin. In some respects the competitive position of the domestic firms can be improved to the extent of providing an encouragement to United States exports. On the other hand, the committee is seriously concerned that the duty advantage may have the effect of encouraging the exports of job opportunities from the United States, particularly in those operations which are labor intensive.

The President requested last year that the U.S. Tariff Commission make a study of these two provisions, and the results of that study were sent to the President on September 30, 1970. The Tariff Commission study recognized that the provision creates opportunities in both directions—increased assembly operations abroad and increased U.S. exports and employment opportunities in cases where the whole manufacturing plant would have moved abroad to take advantage of lower labor costs. As a result, the committee has determined not to propose any changes in the existing provisions. At the same time, the committee would urge that those appropriate agencies in the executive branch promptly review the Tariff Commission report and submit to the Congress recommendations as may be needed to assure that the use of these provisions will not endanger the overall job opportunities of U.S. workers, or encourage working conditions abroad inconsistent with the improvement of labor standards in the United States and in other countries.

OTHER BARRIERS TO TRADE

Further trade liberalization is dependent upon the dismantling of the many unjustifiable and uneconomic burdens on world commerce. The failure to deal with non-tariff barriers is threatening the basic foundation of reciprocity and what the United States believed to be a mutually beneficial exchange of tariff concessions in past negotiations. Despite continued efforts in the General Agreement on Tariffs and Trade and other international forums, including the OECD, and in bilateral discussions, insufficient progress is being made in reducing or eliminating such barriers to international trade. The committee has recognized this growing problem in its amendments to section 252 of the Trade Expansion Act.

There is much that can and should be done in lifting the burdens from U.S. exports, and the administration should vigorously pursue this goal in discussions with our trading partners. One of the difficulties is that the administration does not appear either to have a clear negotiating position on many of the outstanding non-tariff barriers of our trading partners, or to have a shopping list of priorities and a method of negotiating to deal with these problems.

Unlike tariffs, prior Congressional delegation of authority to the President to reduce barriers to trade, other than tariffs, is difficult to embody in legislation because these restrictions often have their roots in purely domestic concerns that are only indirectly related to

foreign trade and are imbedded in domestic laws and practices. Many such barriers would require legislative action to accomplish their removal. To some degree, the nature of such actions might not finally be clear until negotiations had shown what is possible.

In view of these difficulties, the committee does not consider it appropriate or feasible to consider legislation regarding the international negotiations on barriers to trade other than tariffs until the specific details of such legislation are clear. In this respect, representatives of the executive branch should consult with this committee and such other committees of the Congress, as may be appropriate, in the examination of possible changes in domestic law which might be called for as a result of international negotiations in order to benefit from Congressional views on the future development of acceptable standards of conduct in international trade practices. Subject to such consultation and in consideration of the subsequent enactment of any necessary implementing legislation, the President should continue to discuss with other countries the means by which barriers to trade, other than tariffs, can be reduced or eliminated.

In addition, the committee believes that the international harmonization of standards for industrial and agricultural products and the adoption of common quality assurance and certification schemes merit immediate consideration. Decisions being made today with respect to international harmonization of product standards are extremely important to the future growth of U.S. exports. Producers, for example, can manufacture a single model that will meet the requirements of many countries instead of having to manufacture several models to meet varying national standards requirements. And mutual recognition of quality testing saves producers the expense and time involved in undergoing tests in each market. But if these arrangements are exclusive, they become trade barriers by discriminating against the product of third countries. The "Tripartite" agreement among European electrical producers appears to be such a discriminatory device. To prevent such discrimination and to fully enjoy their benefits countries willing and able to assume the responsibilities of membership should be free to join in these undertakings.

In order for the United States to effectively participate in international harmonization and certification schemes there must be full cooperation and coordination between government and industry in standard matters.

Both government and industry should now take whatever steps are necessary to ensure that U.S. exports are not denied the opportunities offered by international efforts directed toward standards harmonization and certification. In particular, this will require adequate funding of U.S. participation in international standards writing and insuring that the United States possesses the institutional facilities necessary to take part in testing and certification arrangements. The Department of Commerce is the logical agency within the U.S. Government to initiate and coordinate these efforts as they relate to industrial products.

STUDY OF MEAT IMPORTS

With respect to the meat import situation, there appear to be some controversy as to whether there is a change in the composition of beef imports. The Tariff Commission is presently working on a

survey of markets for imported beef. Since information will be available to the Department of Agriculture from the Commission, and other sources, the committee requests that the Department of Agriculture provide it with a study on imported meat.

J. TECHNICAL EXPLANATION OF THE AMENDMENT

Section 1. Short title

Section 1 of the bill provides that the bill when enacted may be cited as the "Trade Act of 1970".

PART A—AMENDMENTS TO THE TRADE EXPANSION ACT OF 1962

SUBPART 1—TRADE AGREEMENTS

Section 301. Basic Authority for Trade Agreements

Section 301(a) of the bill amends section 201(a)(1) of the Trade Expansion Act of 1962 (hereinafter in this explanation referred to as "1962 Act") so as to extend until the close of June 30, 1975, the period during which the President may enter into trade agreements with foreign countries and instrumentalities under the 1962 Act.

Section 301(b) of the bill amends section 201(b)(1) of the 1962 Act to provide that no proclamation made by the President to carry out any trade agreement entered into during the period July 1, 1967, through June 30, 1975, may decrease any rate of duty to a rate below the lower of (1) the rate 20 percent below the rate existing on July 1, 1967 (as defined in section 301(d) of the bill); or (2) the rate 2 percent ad valorem (or ad valorem equivalent) below the rate existing on July 1, 1967.

Section 301(c) amends section 201 of the 1962 Act to provide that no proclamation pursuant to subsection (a) shall be made in order to carry out a trade agreement entered into after June 30, 1967, and before July 1, 1975, except to proclaim (1) increased or additional import restrictions or (2) such modifications as may be necessary to fulfill concessions granted as compensation for import restrictions imposed by the United States.

Section 301(d) amends sections 202, 211 (a) and (e), 212, 213(a), and 221 of the 1962 Act. These sections provided that the limits on the authority contained in section 201(b)(1) of the 1962 Act were not to apply in specified cases (so that the rate of duty could have been reduced to zero). The specified cases were articles having a 1962 rate of duty of 5 percent ad valorem or less, articles in any category for which the United States and the European Economic Community accounted for 80 percent or more of the aggregated world export value of all such articles, and certain agricultural, tropical agricultural, and forestry commodities. These amendments make it clear that these exceptions waiving the limitations on the decreases in duty will not apply to the new authority granted by the bill.

Section 301(e) of the bill amends section 256 of the 1962 Act to provide that the rate of duty "existing on July 1, 1967" which may be reduced for the purposes of carrying out a trade agreement entered into on or after such date is the lowest nonpreferential rate of duty (however, established, and even though temporarily suspended by Act of Congress or otherwise) existing on such date or (if lower) the

lowest nonpreferential rate to which the United States was committed on July 1, 1967, and with respect to which a proclamation was in effect on July 1, 1970.

Section 302. Staging Requirements

Subsections (a) and (b) of section 302 of the bill amend subsections (a) and (c) of section 253 of the 1962 Act so as to apply the staging requirements therein only to rate reductions made pursuant to trade agreements entered into under such Act before July 1, 1967.

Section 302(c) of the bill redesignates subsection (d) of such section 253 as subsection (e) and adds a new subsection (d) which provides that any rate reduction made pursuant to a trade agreement entered into under the amendment made by section 301(a) of the bill cannot take effect more rapidly than if it took effect in two equal installments with 1 year intervening between the installments. New section 253(d) also provides that in applying such staging requirements, any reductions with respect to an article made under a trade agreement entered into before July 1, 1967, and which have not taken effect on the date of the first proclamation under a new agreement are to be included within the aggregate duty reduction made with respect to such article under the new agreement.

Section 302(d) of the bill makes technical amendments to section 253(e) (as redesignated by section 302(c) of the bill).

Section 303. Foreign Import Restrictions and Discriminatory Acts

Section 252(a)(3) of the 1962 Act is amended by section 303(a) of the bill to strike out the word "agricultural" each place it appears in the phrase "United States agricultural products". The effect of this change is to provide that the President may, without regard to any provision of a trade agreement, impose duties or other import restrictions on the products of a foreign country in order to obtain the removal, or prevent the establishment, of unjustifiable import restrictions imposed by such country against any type of United States product (whether or not agricultural) and to provide access for any such product to the markets of such country on an equitable basis.

Section 303(b) of the bill amends section 252(b) of the 1962 Act to provide that the action provided for in such section 252(b) (that is, the suspension, withdrawal, or prevention of the application of the benefits of trade agreement concessions; the refraining from proclaiming the benefits of such concessions; or the imposition of duties or other import restrictions under the amendment made by section 103(c) of the bill) is to apply in the case of any foreign country the products of which receive the benefits of trade agreement concessions, if such country provides subsidies (or other incentives having the effect of subsidies) on its exports of one or more products to other foreign markets which unfairly affect the sales of the competitive United States product or products to those other foreign markets.

Section 303(c) of the bill further amends such section 252(b) to include within the action of the President covered by section 252(b) the imposition of duties or other import restrictions on the products of any foreign country or instrumentality which (1) maintains nontariff trade restrictions, (2) engages in discriminatory acts or policies which substantially or unjustifiably burden United States commerce, or

(3) provides subsidies of the type discussed in the preceding paragraph of this explanation, when the President deems such duties and other import restrictions to be necessary and appropriate to prevent the establishment, or obtain the removal, of such restrictions, acts, policies, or subsidies and to provide access for United States products to foreign markets on an equitable basis.

Section 303(d) of the bill amends section 252(c) of the 1962 Act to require (rather than to permit, as is the case under existing section 252(c)) the President to take action (to the extent that such action is consistent with the purposes of section 102 of the 1962 Act) under section 252(c) if a foreign country maintains unreasonable import restrictions which directly or indirectly substantially burden United States commerce.

The amendment by section 303(e) of the bill to such section 252(c) makes the imposition of duties or other import restrictions on the products of the foreign country concerned a third alternative course of action which the President may choose to use in the case of such country. The two alternative courses available under present law are (1) to suspend, withdraw, or prevent the application of benefits of trade agreement concessions to products of such country, or (2) to refrain from proclaiming benefits of trade agreement concessions to carry out a trade agreement with such country.

Section 303(f) amends section 252(d) of the 1962 Act to provide that the Secretary of Commerce upon the request of any interested party shall make an investigation to determine whether any specified restriction established or maintained by, act engaged in, or subsidy provided by a foreign country constitutes (1) a foreign import restriction referred to in subsection (a), (2) a non-tariff trade restriction, discriminatory or other act, or subsidy or the incentive referred to in subsection (b) or (3) an unreasonable import referred to subsection (c); and publish the findings from his investigation within three months after the complaint was filed. If the Secretary makes an affirmative determination, he shall so report to the President, and, after negotiating with the foreign government, the President shall report to the Congress, within three months after receiving the Secretary's report, any actions taken by him under subsections (a), (b), or (c) of the 1962 Act as amended.

Section 303(g) amends the heading for such section 252 to read "Foreign Import Restrictions and Discriminatory Acts".

Section 304. Determinations and Import Adjustments for Safeguarding National Security

Section 304(a) of the bill amends section 232(b) of the 1962 Act to provide that any adjustment of imports under section 232 of such Act is not to be accomplished by the imposition or increase of any duty, or of any fee or charge having the effect of a duty.

Section 304(b) of the bill requires the Director of the Office of Emergency Preparedness to make a determination as to whether an article is being imported in such quantities or under such circumstances as to threaten to impair the national security within 1 year after receiving a request or application for such a determination.

Section 304(c) applies the 1-year limitation discussed in the preceding paragraph to requests or applications received by the Director of the Office of Emergency Preparedness on or after January 1, 1968;

except that a determination with respect to a request or application received after that date and more than 1 year before the date of the enactment of this bill must be made by the Director not later than 60 days after such date of enactment.

SUBPART 2—TARIFF ADJUSTMENT AND ADJUSTMENT ASSISTANCE

Section 311. Petitions and Determinations

Section 311(a) of the bill amends section 301 of the 1962 Act in its entirety.

Section 301(a)(1) of the 1962 Act, as amended by the bill, is the same as existing section 301(a)(1) which provides that a petition for tariff adjustment under section 351 of the Act of 1962 may be filed with the Tariff Commission by a trade association, firm, certified or recognized union, or other industry representative.

Section 301(a)(2) of such Act, as amended by the bill, provides that petitions for determination of eligibility to apply for adjustment assistance under chapter 2 (firm assistance) or chapter 3 (worker assistance) of title III of the 1962 Act may be filed with the President. Under existing law, such petitions are filed with the Tariff Commission. Section 301(a)(2) as amended by the bill also provides that a petition filed by or on behalf of a group of workers shall apply only with respect to individuals who are, or who have been within 1 year before the date on which such petition is filed, employed regularly in the firm involved as full-time or part-time employees.

Subsection (b)(1) of section 301, as amended by the bill, provides that upon the request of the President, upon resolution of either the Committee on Finance of the Senate or the Committee on Ways and Means of the House of Representatives, upon its own motion, or upon the filing of a petition under section 301(a)(1), the Tariff Commission is to promptly make an investigation to determine whether an article upon which a concession has been granted under a trade agreement is, as a result, in whole or in part, of the duty or other customs treatment reflecting such concession, being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause serious injury to the domestic industry producing articles like or directly competitive with the imported article.

The criterion in subsection (b)(1), as amended, for determining whether a domestic industry is being injured by imports differs from that in existing law in that the Tariff Commission presently must determine whether as a result in major part of concessions granted under trade agreements, the article in question is being imported into the United States in such increased quantities as to cause, or threaten to cause, serious injury to the domestic industry producing an article which is like or directly competitive with such imported article. Paragraph (3) of existing section 301(b) provides that for purposes of existing paragraph (1) increased imports are to be considered to cause (or threaten to cause) serious injury when the Tariff Commission finds that such increased imports have been the major factor in causing (or threatening to cause) such injury.

Section 301(b)(2), as amended by the bill, provides that in making an injury determination under section 301(b)(1), the Tariff Commission, without excluding other factors, is to take into consideration a downward trend of production, prices, profits, or wages in the domestic industry concerned, a decline in sales, an increase in unemployment or underemployment, an increase in imports, either actual or relative to domestic production, a higher or growing inventory, and a decline in the proportion of the domestic market supplied by domestic producers.

Section 301(b)(3) sets forth a definition of "domestic industry producing articles like or directly competitive with the imported article" for purposes of applying subsection (b)(1). For purposes of applying the definition, the Tariff Commission is required (insofar as practicable) to distinguish or separate the operations of producing organizations involving like or directly competitive articles from the operations of such organizations involving other articles.

Section 301(b)(4), as amended by the bill, provides that if a majority of the Commissioners of the Tariff Commission who are present and voting on the issue of injury under section 301(b)(1) make an affirmative injury determination, then the Commissioners making such affirmative injury determination are also required to determine under section 301(b)(5) whether the injury to the industry is acute or severe, or threatens to be acute or severe after the Commission make the determinations relating to serious injury and, if affirmative, to acute or severe injury.

Section 301(b)(4) also provides that those Commissioners making an affirmative determination of injury, whether serious, severe or acute shall also determine the amount of the increase in, or imposition of, any duty or other import restriction on such article which is necessary to prevent or remedy the injury to the industry. Any such remedy determination by a majority of the Commissioners making the affirmative injury determination is treated as the remedy determination of the Tariff Commission for the purposes of title III of the 1962 Act (principally for purposes of any tariff adjustment action taken under section 351).

Section 301(b)(5), as amended by the bill, sets forth procedures whereby if an affirmative injury determination is made by the Tariff Commission under section 301(b)(1), the Commissioners voting for such determination are required to make an additional determination. In making this additional determination, such Commissioners look to see if imports are increasing to the point where they are (1) acutely or severely injuring a domestic industry or (2) threatening to acutely or severely injure a domestic industry.

Section 301(b)(6), as amended by the bill, provides that if the Tariff Commission, in the course of any 301(b) investigation, has reason to believe that the increased imports are attributable in part to circumstances which come within the purview of the Antidumping Act, 1921, section 303 or 337 of the Tariff Act of 1930, or other remedial provisions of law, it shall promptly notify the appropriate agency and take such other action as it deems appropriate.

Sections 301(b)(7), (8), and (9) under the bill are the procedural and reporting requirements pertaining to section 301(b)(1) investigations and determinations. They replace similar requirements contained in existing section 301(d)(1), the first sentence of section 301(f)(1), and section 301(f)(2).

Section 301(b)(10) provides that no investigation under section 301(b) may be undertaken by the Tariff Commission, on the basis of any petition filed under section 301(a)(1) of the 1962 Act, with respect to any subject matter which has previously been investigated by it under section 301(b) unless at least 1 year has elapsed since the Commission reported the results of such previous investigation to the President.

Section 301(c)(1) of the 1962 Act, as amended by the bill, provides that in the case of a petition by a firm for a determination of eligibility to apply for adjustment assistance, the President is to determine whether an article like or directly competitive with an article produced by the firm, or an appropriate subdivision thereof, is being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause serious injury to such firm or subdivision.

The President, in making such a determination with respect to a firm, is required to take into account all economic factors which he considers relevant, including idling of productive facilities, inability to operate at a level of reasonable profit, and unemployment or underemployment.

Section 301(c)(2) states that the President is to determine, in the case of a petition by a group of workers for a determination of eligibility to apply for adjustment assistance, whether an article like or directly competitive with an article produced by such workers' firm, or an appropriate subdivision thereof, is being imported into the United States in such increased quantities, either actual or relative, as to contribute substantially (whether or not such increased imports are the major factor or the primary factor) toward causing or threatening to cause unemployment or underemployment of a significant number or proportion of the workers of such firm or subdivision.

The President is required under section 301(c)(3) as amended by the bill to transmit promptly to the Tariff Commission a copy of each firm or worker petition filed under section 301(a)(2) and to request the Commission, not later than 5 days after the date of filing of the petition, to make an investigation of facts relevant to the determinations involved. The Commission must promptly institute, and publish notice in the Federal Register of, an investigation with respect to the petition.

Section 301(c)(4) provides that in the course of any firm or worker petition investigation, the Tariff Commission shall, after reasonable notice, hold a public hearing, if such hearing is requested (which request must be made not later than 10 days after the date of the publication of notice under section 301(c)(3)) by the petitioner or any other interested person, and shall afford interested persons an opportunity to be present, to produce evidence, and to be heard at such hearing.

Section 301(c)(5) requires that the report of the Tariff Commission of the facts disclosed by its investigation under section 301(c)(3) with respect to a firm or group of workers is to be made at the earliest practicable time, but not later than 60 days after the date on which it receives the request of the President for such investigation.

Section 311(b)(1) of the bill provides that the report of any industry injury investigation by the Tariff Commission under section 301(b)(1) of the 1962 Act during the 1-year period ending on the date of the enactment of the bill is to be treated as made more than 1 year before such date for purposes of the requirement of a 1-year interval between investigations of the same matter contained in section 301(b)(10).

Section 311(b)(2) of the bill provides that any industry, firm, or worker investigation under existing section 301 (b) or (c) which is pending before the Tariff Commission immediately before the date of enactment of the bill will be continued as an investigation instituted under section 301 (b) or (c), as amended by the bill, and for purposes of the time periods within which reports by the Tariff Commission with respect to such investigations must be filed, petitions therefor shall be deemed to have been filed on the date of enactment of the bill.

Section 311(b)(3) of the bill provides that any report of an affirmative determination by the Tariff Commission with respect to a firm or worker petition under existing section 301(c) (1) or (2) of the 1962 Act on which the President has not acted by the date of the enactment of the bill is to be treated by him as a report received under section 301(c)(5), as amended by the bill, on such date of enactment.

Section 311(b)(4) of the bill provides that no petition may be filed under section 301(a) of the 1962 Act during the period beginning on the date of enactment and ending on the 90th day after such date, or, if earlier, on the 10th day after the date of publication of the related rules of the Tariff Commission.

Section 312. Presidential Action With Respect to Adjustment Assistance

Section 312(a) of the bill amends section 302(a) of the 1962 Act to provide, under subsection (a)(1) thereof, that the President, if he provides tariff adjustment under section 351 or 352 after receiving an affirmative injury determination under section 301(b), may provide, with respect to such industry, that its firms may request the Secretary of Commerce for certification of eligibility to apply for firm adjustment assistance, that its workers may request the Secretary of Labor for certification of eligibility to apply for worker adjustment assistance, or that both the firms and workers may request such certifications.

Under paragraph (2) of such section 302(a), if the President does not provide tariff adjustment for an industry under section 351 or 352 after receiving an affirmative injury determination under section 301(b), he shall promptly provide that both firms and workers of such industry may request certifications of eligibility for adjustment assistance.

Paragraph (3) of such section 302(a) provides that notice of each action taken by the President under section 302(a) must be published in the Federal Register, and that any request by a firm or group of workers for certification must be made to the Secretary of Commerce or Labor, as the case may be, within the 1-year period after the date on which notice is so published (unless the President specifies a longer period).

Section 312(b) of the bill makes certain conforming amendments to section 302(b) of the 1962 Act to reflect the amendments made to section 302(a) by section 312(a) of the bill. Section 312(b) also amends paragraph (2) of section 302(b) to provide that a certification of eligibility by the Secretary of Labor shall apply only to workers who are, or who have been, employed regularly (on a full-time or part-time

basis) in the firm involved within 1 year before the date of the institution of the applicable Tariff Commission investigation under section 301(b).

Section 312(c) of the bill amends section 302(c) of the 1962 Act to provide under paragraph (1) thereof that after receiving a report of the Tariff Commission of the facts disclosed by its investigation under section 301(c)(3) with respect to any firm or group of workers, the President is to make his determination (with respect to the eligibility of such firm or group to apply for adjustment assistance) not later than 30 days after the date on which he receives such report, unless, within such period, the President requests additional factual information from the Tariff Commission. In that event, the Tariff Commission must, not later than 25 days after the date on which it receives the President's request, furnish such additional factual information in a supplemental report, and the President must make his determination not later than 15 days after the date on which he receives such supplemental report.

Under paragraph (2) of section 302(c), the President is required to publish promptly in the Federal Register a summary of each determination under section 301(c) with respect to any firm or group of workers.

Under paragraph (3) of section 302(c), the President is required to certify promptly that a firm or group of workers is eligible to apply for adjustment assistance if he makes an affirmative determination under section 301(c) with respect to the firm or group.

Paragraph (4) of such section authorizes the President to delegate to any agency or other instrumentality of the United States any of his functions with respect to determinations and certifications of eligibility of firms or workers to apply for adjustment assistance under sections 301 and 302.

Section 312(d) amends the heading of section 302 to read "Presidential Action with Respect to Adjustment Assistance."

Section 313. Tariff Adjustment

Section 313(a) of the bill amends paragraph (1) of section 351(a) of the 1962 Act to provide, under subparagraph (A) thereof, that after receiving an affirmative injury determination of the Tariff Commission under section 301(b)(1), which is not combined with an additional affirmative determination of the Commission under section 301(b)(5), the President is to proclaim such increase in, or imposition of, any duty or other import restriction on the article concerned as he determines to be necessary to prevent or remedy serious injury to the industry, unless he determines that such action would not be in the national interest.

Under paragraph (1)(B) of such section 351(a), as amended by the bill, if the President receives an affirmative injury determination of the Tariff Commission under section 301(b)(1) which is combined with an affirmative additional determination of the Commission under section 301(b)(5), he shall proclaim the increase in, or imposition of, any duty or other import restriction on the article concerned determined and reported by the Commission pursuant to section 301(b), unless he determines that such action would not be in the national interest.

Section 313(a) of the bill also makes certain conforming amendments to paragraph (2) of section 351(a). Paragraph (2) sets forth procedures whereby, if the President does not proclaim the increase in, or imposition of, any duty or other import restriction on the article

concerned determined and reported by the Tariff Commission under section 301(b), the Congress can (by the adoption of a concurrent resolution) cause such increase or imposition to take effect. Such paragraph (2) is also amended to provide that if the President does not proclaim the remedy determined by the Tariff Commission because of considerations of national interest, he is not required to state the considerations on which his decision was based.

Subsections (b) and (c) of such section 113 make certain conforming amendments to paragraphs (3) and (4) of section 351(a).

Section 313(d) of the bill makes certain amendments to section 351(d)(1) which provides that the Tariff Commission must keep under review developments with respect to the industry concerned after tariff adjustment for such industry is proclaimed. One amendment requires that the Commission, in making such review, take into account the specific steps taken by firms in the industry to enable them to compete more effectively with imports. Another amendment requires the Commission to take such steps into account when, at the request of the President, it advises him under section 351(d)(2) of the probable economic effect on the industry concerned of the reduction or termination of the increase in, or imposition of, any duty or other import restriction previously proclaimed under section 351. Such section 351(d) is further amended by the addition of a new paragraph (6) which provides that the Tariff Commission, in making any investigation initiated under paragraph (2) or (3) of section 351(d), shall also determine and report to the President if the termination of the proclaimed increase or imposition threatens to cause serious injury to the industry concerned, and if such determination is affirmative, (1) the limit to which such increase or imposition may be reduced without threatening to cause serious injury to the industry concerned, and (2) whether, in lieu of such termination, additional increases or impositions of duties and other import restrictions are required to prevent or remedy serious injury to the industry concerned.

Section 314. Orderly Marketing Agreements

Section 314 of the bill amends section 352(a) to provide that the President may at any time after receiving an affirmative injury determination of the Tariff Commission with respect to an industry negotiate international agreements with foreign countries to limit the export to, and import into, the United States of the article causing or threatening to cause serious injury to such industry. Any such agreement may replace in whole or part any tariff adjustment action taken by the President under section 351, but any such agreement entered into before such time as the Congress takes action under section 351(a)(2) which has the result of placing the Tariff Commission remedy in effect must terminate on the date the President proclaims such remedy pursuant to section 351(a)(3).

Section 315. Increased Assistance for Workers

Section 315(a) amends section 323(a) of the 1962 Act to provide that the trade readjustment allowance payable under such section 323(a) to workers found eligible for adjustment assistance is an amount equal to 75 percent of his average weekly wage or to 75 percent of the average weekly manufacturing wage, whichever is less, reduced by 50 percent of the amount of his remuneration for services performed during such week. Under existing law the applicable percentage of his weekly wage or the weekly manufacturing wage is 65 percent.

Section 315(b) of the bill amends section 326(a) of the 1962 Act so as to make it clear that "supportive and other services" provided for under any Federal law are among the services which can be afforded to adversely affected workers in order to prepare them for full employment.

Under section 315(c) of the bill, the increased trade readjustment allowances provided for under the amendment made by section 515(a) applies with respect to weeks of unemployment beginning on or after the date of enactment of the bill.

Section 316. Conforming Amendments

Section 316 of the bill makes conforming amendments to sections 242(b)(2), 302(b), 311(b)(2), and 317(a)(2) of the 1962 Act.

PART B—QUOTAS ON CERTAIN TEXTILE AND FOOTWEAR ARTICLES

SUBPART 1—TEXTILE AND FOOTWEAR ARTICLES

Section 321. Annual Quotas

Section 321(a) of the bill establishes a statutory quota for calendar year 1971 under which the total quantity of each category of textile articles, and the total quantity of each category of footwear articles, produced in any foreign country which may be entered for consumption in the United States during such year may not exceed the average annual quantity of such category produced in such country and entered during 1967, 1968, and 1969.

Paragraph (1) of section 321(b) of the bill provides that the statutory quota applicable to each category of textile articles and to each category of footwear articles produced in any foreign country which may be entered in the United States during 1972 and any calendar year thereafter may not exceed the total quantity determined for such category for such country under section 321(a), as increased by the President for any calendar year after 1971 and before the current calendar year under paragraph (2)(A) of section 321(b), plus any further increase in such quantity for the current calendar year which may be provided for by the President under such paragraph (2)(A).

Paragraph (2)(A) of section 321(b) provides that the President may increase the total quantity of each category of textile articles, and the total quantity of each category of footwear articles, produced in any foreign country which may be entered during any calendar year after 1971 by such percentage (but not exceeding 5% of the total quantity determined for such category for such country under section 321(a) or section 321(b) for the immediately preceding calendar year) as he determines to be consistent with the purposes of section 321.

Paragraph (2)(B) provides that any annual increase in any category authorized by the President under paragraph (2)(A) for any calendar year must be the same percentage for all foreign countries.

Paragraph (2)(C) requires that a determination of the total quantity of each category of articles for each foreign country be made under section 321(a) and (b) for each calendar year after 1971 notwithstanding the fact that the statutory quota provided for therein may not apply during the whole or part of such year by reason of the application of other provisions of Subpart B of title III of the bill or the provisions

of the Arrangement or the Agreement referred to in section 324(b) of the bill. Where any category of articles for a foreign country is affected by the nonapplication of the statutory quota to one or more articles falling within such category, for purposes of subsections (a) and (b) of section 201 the remaining articles in such category shall, for purposes of that country and for the period of such nonapplication of the statutory quota, be treated as having constituted a separate category for such country for all years after 1966. The application of the preceding sentence would yield, of course, to a change in the category or categories concerned effected under paragraph (3) of section 326 of the bill after compliance with section 205(a) of the bill (relating to rulemaking procedures).

Paragraph (3) of section 321(b) provides that if (1) the statutory quota does not apply (for any of the reasons mentioned in the preceding paragraph of this explanation) with respect to any textile article or footwear article produced in a foreign country, but (2) at any time after 1971 a statutory quota begins to apply to, or resumes in application to, such article produced in such country, and (3) the President determines (A) that the average annual quantity of the article, produced in such country, and entered in the United States during 1967, 1968, and 1969 was insignificant, and (B) that the application of section 321(b)(3) to the category which includes such article for such country is consistent with the purposes of section 321, then for the calendar year in which such termination occurs, the statutory quota applicable with respect to the quantity of the category including such article, produced in such country, shall be deemed to be the annual average quantity (of such category) which was entered during the 3 calendar years immediately preceding such calendar year of termination (rather than during the 1967-69 base period provided for in section 521(a)) plus any applicable yearly increases for periods after 1971.

Section 321(c)(1) of the bill provides that any annual quantitative limitation under section 321(a) or (b) shall be applied on a calendar quarter or other intra-annual basis if the President determines that such application is necessary or appropriate to carry out the purposes of section 321.

Paragraph (2) of section 321(c) of the bill provides that if the application of section 321 (a) or (b) to any category for any foreign country begins or resumes after the first day of any calendar year, then the amount of the quota for such category for such country for the remainder of such calendar year shall be the annual amount determined under section 321 (a) or (b), adjusted pro rata according to the number of full months remaining in the calendar year after the date of such beginning or such resumption.

Under section 321(d)(1) of the bill the President may exempt from the statutory quota determined under section 321 (a) and (b) for an initial period of not to exceed 1 year any textile article or footwear article produced in any foreign country if he determines that imports of such article produced in such country are not contributing to, causing, or threatening to cause market disruption in the United States. Any such exemption may be extended by the President for one or more additional periods of not in excess of 1 year each if he makes a new determination (before each such extension) that imports of such article produced in such country are not contributing to,

causing, or threatening to cause market disruption in the United States.

The President may terminate an exemption made under paragraph (1) of section 321(d) of the bill at any time upon his finding that the article covered by such exemption is contributing to, causing, or threatening to cause market disruption in the United States.

Paragraph (2) of section 321(d) provides that the President may exempt from section 321 (a) and (b) any textile article or footwear article produced in any foreign country whenever he determines that such an exemption is in the national interest, and the President may terminate any such exemption whenever he determines that such termination is in the national interest.

Paragraph (3) of section 321(d) provides that no exemption, extension of an exemption, or termination of an exemption under section 321(d) (1) or (2) may take effect sooner than the 30th day after the day on which notice of such exemption, extension, or termination is published in the Federal Register.

Under paragraph 321(e) of the bill, the Secretary of Commerce is required to compute quantities under the statutory quotas provided for in section 321 (a) and (b) of the bill.

Section 322. Arrangement or Agreements Regulating Imports

Section 322(a) of the bill authorizes the President to conclude bilateral or multilateral arrangements or agreements with the governments of foreign countries for the purpose of regulating, by category, the quantities of textile articles or footwear articles, or both, produced in those countries which may be exported to, or entered for consumption in, the United States. The President is authorized to issue regulations necessary to carry out the terms of such arrangements or agreements. The President is required, in concluding any such arrangement or agreement, to take into account conditions in the United States market, the need to avoid disruption of that market, and such other factors as he deems appropriate in the national interest.

Section 322(b) of the bill provides that whenever a multilateral arrangement or agreement concluded under section 322(a) is in effect among the countries, including the United States, which account for a significant part of world trade in the article concerned and such arrangement or agreement contemplates the establishment of limitations on the trade in the article produced in countries not parties to such arrangement or agreement, the President may by regulation establish the total quantity of the article produced in each country not a party to such arrangement or agreement which may be entered for consumption in the United States. Section 322(b) provides, however, that such regulations may not have the effect of reducing the total quantity for any category for any country for any calendar year to an amount less than the total quantity which would be permitted to be entered if section 321 (a) and (b) (the statutory quota) applied to such category for such country for such year.

Section 322(c) of the bill states that neither the statutory quota nor exemption provisions of section 321 of the bill are to apply to imported articles which are subject to an arrangement or agreement entered into under section 322(a) or to regulations issued under section 202(b).

Section 323. Increased Imports Where Supply Is Inadequate To Meet Domestic Demand at Reasonable Prices

Section 323 of the bill permits the President, in carrying out sections 321 and 322, to authorize increased exports to the United States or increased entries in the United States of textile articles or footwear articles of any category if he determines that the supply of textile articles or footwear articles similar to those subject to limitation under such sections will be inadequate to meet domestic demand at reasonable prices.

Section 324. Exclusions

Section 324(a) of the bill exempts from the import restrictions provided for in part B of title III of the bill any article exempted from duty under part 2 of schedule 8 of the Tariff Schedules of the United States (personal exemptions) and any article the entry of which is regulated pursuant to paragraph (4), (5), (6), or (7) of section 498(a) of the Tariff Act of 1930 (relating to household effects, gifts from abroad, tools of trade, and certain other personal articles). Section 204(a) also provides that, to the extent provided in regulations prescribed by the Secretary of Commerce, the import restrictions provided for in part B of title III of the bill will not apply to other articles imported in noncommercial quantities for noncommercial purposes. Such regulations may include provision for the nonapplication of quotas to commercial samples, not for sale or use other than as samples, under safeguards which will ensure that such provision will not be used to weaken the effectiveness of part B of title III of the bill.

Section 324(b) exempts from the application of part B of title III (1) articles subject to the Long-Term Arrangement Regarding International Trade in Cotton Textiles, so long as the United States is a party thereto, and (2) articles produced in the Philippines provided for in item B (cordage) in the schedule to paragraph 1 of article II of the 1955 Agreement With the Philippines Concerning Trade and Related Matters, so long as such Agreement remains in effect.

Section 324(c) of the bill provides that nothing in title III affects the authority provided for under section 22 of the Agricultural Adjustment Act of 1933, as amended.

Section 325. Administration

Section 325(a) of the bill applies the rulemaking provisions of subchapter II of chapter 5 of title 5, United States Code, to section 321(b)(2) (yearly increases in statutory quota amounts); 321(b)(3) (application of special statutory quota base in the case of countries providing insignificant imports during 1967-69); 321(d)(1) (exemptions from statutory quota for articles not causing market disruption); 322(b) (regulations limiting imports from countries not party to certain multilateral arrangements or agreements entered into under section 202(a)); 203 (increased imports in cases where supply is inadequate to meet domestic demand at reasonable prices); 324(a) (regulatory determination of articles excluded from quota if imported in noncommercial quantities for noncommercial purposes); and 326 (article and category definitions).

Section 325(b) of the bill requires that all quantitative limitations established under part B of title III of the bill or pursuant to any arrangement or agreement entered into under such title, all exemptions established under such title and all extensions or terminations

thereof, and all regulations promulgated to carry out such title be published in the Federal Register.

Under section 325(b), the Secretary of Commerce is required to certify to the Secretary of the Treasury for each period the total quantity of each textile article and footwear article produced in each foreign country the entry of which is affected by any such quantitative limitation on importation; and the Secretary of the Treasury is directed to take such action as may be necessary to ensure that the total quantity so entered during such period does not exceed the total quantity so certified.

Section 325(c) requires that all quantitative limitations and exemptions established under part B of title III or pursuant to any arrangement or agreement entered into under such title and all quantitative limitations established pursuant to the Long-Term Arrangement Regarding International Trade in Cotton Textiles be promulgated as a part of the appendix to the Tariff Schedules of the United States, Annotated.

Section 326. Definitions

Section 326 of the bill contains six definitions which are applicable for purposes of part B of title III of the bill.

Section 326(1) of the bill defines "textile article" to include—

(1) any article if wholly or in part of cotton, wool or other animal hair, human hair, man-made fiber, or any combination or blend thereof, or cordage of hard (leaf) fibers, classified under schedule 3 of the Tariff Schedules of the United States;

(2) any article classified under subpart B or C of part 1 of schedule 7 of such schedules if wholly or in substantial part of cotton, wool, or man-made fiber;

(3) any other article specified by the Secretary of Commerce which he has been advised by the Secretary of the Treasury would be classified under any of the provisions of the schedules referred to in paragraph (1) or (2) above but for the inclusion of some substance, material, or other component, or because of its processing, which causes the article to be classified elsewhere; and

(4) any article provided for under paragraph (1), (2), or (3) above if entered under item 807.00 of such schedules (relating to articles assembled abroad in whole or in part of certain components fabricated in the United States), or under the appendix to such schedules.

Such section 326(1) does not include within the term "textile article" any article classified under any of items 300.10 through 300.50, 306.00 through 307.40, 309.60 through 309.75, and 390.10 through 390.60, inclusive, of the Tariff Schedules.

Section 326(2) defines the term "footwear article" to include footwear provided for in any of items 700.05 through 700.45, inclusive, item 700.55, items 700.66 through 700.80, inclusive, and item 700.85 of the Tariff Schedules of the United States.

Section 326(3) defines the term "category" to mean a grouping of textile articles, or a grouping of footwear articles, as the case may be, as determined by the Secretary of Commerce, for the purposes of part B of title III of the bill, using the five-digit and seven-digit item numbers applied to such articles in the Tariff Schedules of the United States, Annotated.

Section 326(4) defines the term "entered" as meaning entered, or withdrawn from warehouse, for consumption in the customs territory of the United States.

Section 326(5) defines the term "produced" to mean manufactured or produced.

Section 326(6) defines the term "foreign country" to include a foreign instrumentality. For this purpose the term "country" is used in an all inclusive sense; a dependency or colony which is not treated as part of another country is to be treated as a separate country.

SUBPART 2—EFFECTIVE PERIOD

Section 331. Termination of Title, Extension Under Certain Conditions

Section 331(a) of the bill provides that title III of the bill which establishes quotas on certain textile and footwear articles is to terminate at the close of July 1, 1976, unless extended under section 331(b).

Section 331(b) provides that the effective period of part B of title III of the bill may be extended in whole or in part by the President after July 1, 1976, for such periods (not to exceed 5 years at any one time) as he may designate if after seeking advice of the Tariff Commission and of the Secretary of Commerce and of the Secretary of Labor, the President determines that such extension is in the national interest.

Under section 331(c) the President is required to report promptly to Congress with respect to any action taken by him to extend the effective period of part B of title III.

Section 331(d) states that nothing in section 331 affects the validity of any arrangement or agreement entered into under section 322(a) before the termination of part B of title III or of any regulations issued under subsection (a) or (b) of section 322 in connection with any arrangement or agreement entered into under section 322(a) before such termination.

PART C—OTHER TARIFF AND TRADE PROVISIONS

SUBPART 1—AMENDMENTS TO THE ANTIDUMPING AND COUNTERVAILING DUTY LAWS

Section 341. Antidumping Act, 1921

Section 341(a) of the bill amends section 201(b) of the Antidumping Act, 1921, to provide that the Secretary of the Treasury or his delegate must, within 4 months after a question of dumping is raised by or presented to him, make the determination required under present law as to whether there is reason to believe or suspect that the purchase price of imported merchandise is less, or the exporter's sales price is less or likely to be less, than the foreign market or constructed value of the merchandise. If the Secretary's determination is in the affirmative, then under paragraph (2) of such section 201(b), as amended by the bill, he must publish notice thereof in the Federal Register and require the withholding of appraisement of any such merchandise entered on or after such date of publication. Such paragraph (2) also retains the present provision in the Antidumping Act which authorizes the Secretary to order that such withholding be made effective with respect to merchandise entered on or after an earlier date, but in no

case may the effective date of withholding be earlier than the 120th day before the question of dumping was raised by or presented to him.

Paragraph (3) of such section 201(b) provides that if the Secretary's determination is negative, notice thereof must be published in the Federal Register, but the Secretary may within 3 months thereafter order the withholding of appraisement if he then has reason to believe or suspect that dumping is involved; an order of withholding of appraisement in that case is treated in the same manner as is a withholding under paragraph (2) of section 201(b). Such section 201(b) as amended by the bill also provides that the question of dumping is deemed to have been raised by or presented to the Secretary on the date on which a notice is published in the Federal Register that information relating to dumping has been received in accordance with regulations prescribed by him.

Section 341(b)(3) also provides that if the Secretary determines within 2 months after the question of dumping was raised that the circumstances are such that a determination cannot reasonably be made within 4 months, he shall publish notice to that effect, and in such cases, may take up to 7 months after the question of dumping was raised to reach a determination.

Section 341(b) of the bill adds a new subsection (b) to section 205 of the Antidumping Act, 1921, which provides that if available information indicates to the Secretary of the Treasury that the economy of the country from which merchandise is exported is state-controlled to an extent that sales of such or similar merchandise in that country or to countries other than the United States do not permit a determination of foreign market value under section 205(a) of such Act, he shall determine the foreign market value of the merchandise on the basis of the normal costs, expenses, and profits as reflected by either (1) the prices at which such or similar merchandise of a non-state-controlled-economy country is sold either for consumption in the home market of that country, or to other countries, including the United States; or (2) the constructed value of such or similar merchandise in a non-state-controlled-economy country as determined under section 206 of the Antidumping Act, 1921.

Section 341(c) of the bill makes the amendment made by section 341(a) of the bill effective on the 180th day after the date of enactment of the bill.

Section 341(c) of this title amends section 210 of the Antidumping Act to make it clear that the right of protest referred to in section 210 includes the right of an American manufacturer, producer or wholesaler of merchandise of the same class or kind as foreign merchandise which is the subject of a determination by the Secretary under section 201(c). This section 341(c) also amends section 516 of the Tariff Act of 1930 to add a new subsection (d) which would provide the procedure for the U.S. manufacturer, producer or wholesaler of merchandise to protest a negative dumping decision by the Secretary of Treasury.

Section 342. Countervailing Duties

Section 342(a) of the bill amends section 303 of the Tariff Act of 1930 in its entirety, although retaining many of the provisions of existing section 303. Subsection (a)(1) of the amended section 303 pro-

vides that whenever any country or other governmental entity or private entity, pays or bestows any bounty or grant upon the manufacture, production, or export of any article or merchandise manufactured or produced in such country or subdivision thereof, then upon the importation of such article or merchandise into the United States, whether imported directly from the country of production or otherwise, and whether such article or merchandise is imported in the same condition as when exported or has been changed in condition by remanufacture or otherwise, there is to be levied and paid with respect to such article or merchandise, in addition to any duties otherwise imposed, a duty equal to the net amount of such bounty or grant. The bill adds the requirement that the Secretary of the Treasury must determine, within 12 months after the date on which the question is presented to him, whether any bounty or grant is being paid or bestowed.

Section 303(a)(2) as added by the bill requires that in the case of any imported article or merchandise which is free of duty, duties may be imposed under section 303 only if there is an affirmative determination by the Tariff Commission under section 303(b)(1).

Section 303(a)(3) retains the requirement in existing section 303 that the Secretary from time to time must ascertain and determine, or estimate, the net amount of each such bounty or grant, and declare the net amount so determined or estimated.

Under section 303(a)(4) the Secretary is required to make all regulations he may deem necessary for the identification of articles and merchandise covered by section 303 and for the assessment and collection of the duties thereunder. Such paragraph (4) also provides that all determinations by the Secretary under section 303(a), and all determinations by the Tariff Commission under section 303(b)(1), whether affirmative or negative, are to be published in the Federal Register.

Under section 303(b)(1), as added by the bill, the Secretary of the Treasury must, whenever he determines that a bounty or grant is being paid with respect to duty-free merchandise, advise the Tariff Commission which shall determine within 3 months thereafter, and after such investigation as it deems necessary, whether an industry in the United States is being or is likely to be injured, or is prevented from being established, by reason of the importation of such article or merchandise into the United States and notify the Secretary of that determination. The Secretary is further required, under such regulations as he may prescribe, to suspend liquidation of any such article or merchandise which is entered, or withdrawn from warehouse, for consumption, on or after the 30th day after the date of the publication in the Federal Register of his determination under section 301(a)(1), and such suspension will continue until further order of the Secretary.

New section 303(b)(2) provides that if the determination of the Tariff Commission under section 303(b)(1) is affirmative, the Secretary is to make public an order directing the assessment and collection of duties in the amount of such bounty or grant as is from time to time ascertained and determined, or estimated, under section 303(a).

Subsection (c) of the amended section 303 provides, that an affirmative determination by the Secretary of the Treasury under section 303(a)(1) with respect to any imported article or merchandise which (1) is dutiable, or (2) is free of duty but with respect to which the

Tariff Commission has made an affirmative determination under section 303(b)(1), applies with respect to articles entered, or withdrawn from warehouse, for consumption on or after the 30th day after the date of the publication in the Federal Register of such determination by the Secretary.

Section 303(d) as added by the bill provides that no countervailing duty is to be imposed with respect to any article which is subject to a quantitative limitation imposed by the United States on its importation, or subject to a quantitative limitation on its exportation to or importation into the United States imposed under an agreement to which the United States is a party, unless the Secretary of the Treasury determines, after seeking information and advice from such agencies as he deems appropriate, that such quantitative limitation is not an adequate substitute for the imposition of a countervailing duty. This determination is to be made on an article-by-article basis. Furthermore, in the case of a quantitative limitation with respect to an article which applies only if the article does not exceed a stated value, the determination shall be made as if the article, when valued below the stated amount, constituted a separate article.

Section 342(b) of the bill provides that the amendment made by section 342(a) takes effect on the date of the enactment of the bill, except that the last sentence of section 303(a)(1) of the Tariff Act of 1930 (requiring that bounty determinations be made within 12 months after presented) applies only with respect to questions regarding bounties presented on or after such date of enactment.

SUBPART 2—TARIFF COMMISSION

Section 351. Independent Status of the Tariff Commission

Section 351 of this title amends section 330 of the Tariff Act of 1930 to provide that except as otherwise specifically provided by law, the Tariff Commission shall be independent of the Executive.

SUBPART 3.—THE GENERAL AGREEMENT ON TARIFFS AND TRADE

Section 361 of this title would direct the Executive Branch to study and submit to the Congress reports on important issues involved in international trade.

Section 361(a) would involve all presently existing provisions and interpretations of the GATT. It would include but not be limited to:

(1) The most favored nation principle, the special exceptions thereto, the effect of these exceptions on U.S. trade and investment patterns;

(2) The provisions on export subsidies and border taxes and the rationale underlying the different treatment of direct and indirect taxes insofar as border tax adjustments are concerned;

(3) The adequacy of provisions on agricultural trade;

(4) The adequacy of provisions dealing with balance of payments matters;

(5) The provisions on unfair trade practices and relief from injurious imports; and

(6) The provisions on "compensation" and "retaliation."

Section 361(b) would direct the Executive Branch to study a number of specific problems including:

(1) A United States negotiating position with respect to the quantitative restrictions that remain in effect in many countries;

(2) The border tax—export rebate system of the European Community with particular reference to U.S. countervailing duty laws;

(3) The common agricultural policies of the European Community;

(4) Discriminatory government procurement policies;

(5) The probable effects of British entry into the Common Market on United States trade and balance of payments;

(6) The effect of foreign exchange-rate changes on U.S. trade and tariff concessions;

(7) An analysis of whether or not greater flexibility in foreign exchange rates would serve in the interests of United States and world trade;

(8) The nature and extent to which other countries subsidize their exports directly or indirectly;

(9) A comparative analysis of various proposals to extend "tariff preferences" to the products of less developed countries with particular emphasis on the effects on U.S. trade and investment patterns and on U.S. labor; and

(10) The various agency responsibilities within the Executive Branch for handling all U.S. foreign trade matters, and the means by which policy coordination is achieved.

Section 361(c) of this title provides that the Executive shall complete these studies by December 31, 1971.

Section 362 of this title directs the Tariff Commission to conduct studies and submit reports on them to the Committee on Finance not later than December 31, 1971, on the following subjects:

(1) The tariff and nontariff barriers among the principal trading nations in the industrialized countries, including an analysis of the disparity in tariff treatment of similar articles of commerce by different countries. This analysis is to explore the reasons for the disparities;

(2) The nature and extent of the tariff concessions granted in the GATT by the principal trading nations in the industrialized countries;

(3) (a) The foreign customs valuation procedures and those of the United States with a view to developing and suggesting uniform standards of custom valuation which would operate fairly among all classes of shippers in international trade and (b) the economic effects which follow if the United States adopts such standards of valuation, based on rates of duty which will become effective on January 1, 1972; and

(4) The implications of multinational firms on the patterns of world trade and investment and on U.S. trade and labor.

It is the committee's expectation that these studies will lead to constructive proposals for international principles for insuring free and fair competition in world markets and which would guarantee *reciprocity* for U.S. trade and investment. Only on the basis of the full facts can the committee and the Congress exercise its Constitutional prerogative and responsibilities in the field of international trade.

SUBPART 4—MISCELLANEOUS PROVISIONS

Section 371. Amendments to Automotive Products Trade Act of 1965

Section 371(a) of the bill amends section 302(a) of the Automotive Products Trade Act of 1965 to authorize the filing of petitions by firms or groups of workers with the President for certifications of eligibility to apply for adjustment assistance under title III of the 1962 Act. Under existing law, the last day on which such petitions could be filed was June 30, 1968.

Section 371(b) amends the side heading of section 302 of such Act of 1965 to read "Special Authority".

Section 371(c) amends subsections (c) and (d) of such section 302 to provide that in determining whether groups of workers or firms are eligible to apply for adjustment assistance, the President is to consider whether or not the operation of the Agreement Concerning Automotive Products Between the Government of the United States of America and the Government of Canada has been a substantial factor (rather than the primary factor, as under existing law) in causing or threatening to cause dislocation of the firm or group of workers. Section 371(c) also makes a conforming change in section 302(g)(2) of such act of 1965.

Section 371(d) provides that the amendments made by section 341 apply with respect to petitions for certification of eligibility filed after the date of the enactment of the bill, except that such amendments will apply only with respect to dislocations which began after June 30, 1968. Where such a dislocation began after June 30, 1968, and before July 1, 1970, such amendments will apply only if the petition concerned is filed on or before the 90th day after such date of the enactment.

Section 371(e) directs the President to secure elimination by the Government of Canada of its duties and other import restrictions on automobiles produced in the United States. If this is not achieved before January 1, 1973, the amendment directs the President to exercise the authority conferred on him by section 204 of the Automotive Products Act of 1965 to terminate in whole or in part proclamations issued under such Act.

Section 372. Rates of Duty on Mink Furskins; Repeal of Embargo on Certain Furs

Section 372(a)(1) of the bill adds new items to schedule 1, part 5, subpart B of the Tariff Schedules to establish a tariff rate quota on mink furskins. A quota of 3,600,000 skins is established for each calendar year and is allocated on a quarterly basis. Raw or not dressed skins entered within the quota are duty free (as at present) if the column 1 rate applies and dutiable at 30% ad valorem if the column 2 rate (rate applied if the article is the product of a designated Communist country) applies. Dressed furskins entered within the quota, if in the form of plates, mats, linings, strips, crosses, or similar forms, are dutiable at 12% ad valorem if not dyed (35% ad valorem if the column 2 rate applies) and at 14% ad valorem if dyed (40% ad valorem under column 2). Other dressed furskins entered within quota if not dyed are dutiable at 3.5% ad valorem (25% ad valorem under column 2) and if dyed are dutiable at 5.5% ad valorem (30% ad valorem under column 2). Any furskin, whether or not dressed and whether dyed or

not dyed, which is entered in a calendar year after the quota for that year is filled is dutiable at 25% ad valorem under column 1 and 40% ad valorem under column 2.

Section 372(a)(2) adds a new item 791.12 to schedule 7, part 13, subpart B of the Tariff Schedules making garments of mink dutiable at 14% ad valorem under column 1 and at 50% ad valorem under column 2.

Section 372(b) repeals the existing embargo in headnote 4 to schedule 1, part 5, subpart B of the Tariff Schedules on ermine, fox, kolinsky, marten, mink, muskrat, and weasel furskins, raw or not dressed or dressed, which are the product of the Soviet Union or Communist China and applies a duty of 30% ad valorem on these articles, raw or not dressed.

Section 372(c) makes the amendments and the repeal effected by section 372 of the bill applicable with respect to articles entered, or withdrawn from warehouse, for consumption on or after January 1, 1971.

Section 373. Rate of Duty on Glycine and Certain Related Products

Section 373(a) of title III of the bill amends schedule 7, part 13, subpart B of the Tariff Schedules to provide a tariff rate quota on glycine (aminoacetic acid) and salts thereof, and certain mixtures of glycine or its salts. Under the quota, the first 1,500,000 pounds of the articles entered during any calendar year, and the first 375,000 pounds entered during any calendar quarter are dutiable at 8.5% ad valorem if the column 1 rate applies and at 25% ad valorem if the column 2 rate applies. Glycine, salts, and mixtures entered after the annual quota is filled in a calendar year or the quarterly quota is filled in a calendar quarter are dutiable at 8.5% ad valorem plus 25 cents per pound under column 1 and at 25% ad valorem plus 25 cents per pound under column 2.

Section 373(b) makes the tariff rate quota established in section 344(a) effective with respect to articles entered on or after January 1, 1971.

Section 374. Ski Bindings

Section 374 of the bill amends schedule 7, part 5, subpart D of the Tariff Schedules to provide a new rate on parts of ski bindings (TSUS 734.97) of 3% ad valorem on January 1, 1971.

Section 375. Invoice Information

Section 375 of title III of the bill amends section 481(a) of the Tariff Act of 1930 (relating to information required on invoices of imported merchandise) to require that such invoices contain such information as to product description as is required to be made a part of the entry by provisions of the Tariff Schedules of the United States, Annotated.

Section 376. Reports of Imports and Exports

Section 376 of title III of this bill amends section 301 of title 13 of the United States Code to require the Secretary of Commerce in compiling and publishing any information:

- (1) With respect to imports to state:
 - (A) The dutiable value of the imported article; and
 - (B) The c.i.f. value of the imported article; and

(2) With respect to exports to state separately from the total value of all exports:

(A) (i) the value of agriculture commodities exported under the Agricultural Trade Development and Assistance Act of 1954, as amended; and

(ii) the total amount of all export subsidies paid to exporters by the United States under such Act for the exportation of such commodities; and

(B) the value of goods exported under the Foreign Assistance Act of 1961.

Section 377. Certain Meat and Meat Products

Section 377 of title III of the bill amends Public Law 88-482 to include "prepared" fresh, chilled and frozen beef and veal in the basic meat import quota provisions of that Act and to allocate the annual total quantities of all meats subject to import limitations on a quarterly basis.

Section 378. Trade With Foreign Countries Permitting Uncontrolled Production of or Trafficking in Certain Drugs

Section 378 of title III of the bill authorizes the President of the United States to impose an embargo or suspension of trade with a nation which permits the uncontrolled or unregulated production of or trafficking in opium, heroin, or other poppy derivatives in a manner to permit these drug items to fall into illicit commerce for ultimate disposition and use in the United States.

**VIII. AMENDMENTS TO PUBLIC ASSISTANCE PRO-
GRAMS AND WORK INCENTIVE PROGRAM**

Amendments to Public Assistance Programs and Work Incentive Program

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VIII. AMENDMENTS TO PUBLIC ASSISTANCE PROGRAMS AND WORK INCENTIVE PROGRAM

A. AID TO THE AGED, BLIND, AND DISABLED

The committee has a continuing deep concern for those of our citizens who are in financial need because of old age or because of blindness or other crippling disabilities. Accordingly, the committee bill adds provisions to the House bill which significantly improve welfare benefits for such individuals. At the same time, recognizing the already heavy burden of welfare expenditures faced by the States, the committee has included in the bill provisions which will not only assure no increase in State costs because of the improvements in welfare for the aged, blind, and disabled, but will also actually reduce State budgets for these programs.

NATIONAL MINIMUM INCOME STANDARD FOR THE NEEDY AGED, BLIND, AND DISABLED

(Sec. 501 of the bill)

Under present law, each State determines the level of assistance which it will provide to needy persons under the Federally-matched programs of aid to the aged, blind, and disabled. The committee recognizes that this arrangement is basically sound in that it allows each State to design its program in accord with its resources and with the level of costs prevailing within the States. However, the committee also feels that it is both possible and appropriate to establish by Federal law a minimum level of income support applicable on a nationwide basis to all needy persons who are aged, blind, or disabled. Accordingly, the committee bill would require States to provide a level of assistance sufficient to assure persons in these categories a total monthly income from all sources of at least \$130 for a single individual and at least \$200 for a couple. Each State would, of course, remain free to continue or establish a higher standard.

Old-age assistance: State needs standards and payment levels

	Single person		Couple	
	Standard of need	Payment to person with no other income	Standard of need	Payment to couple with no other income
Alabama.....	\$140	\$97	\$235	\$194
Alaska.....	211	211	273	273
Arizona.....	118	85	164	164
Arkansas.....	135	94	224	188
California.....	171	171	306	306

Old-age assistance: State needs standards and payment levels—Continued

	Single person		Couple	
	Standard of need	Payment to person with no other income	Standard of need	Payment to couple with no other income
Colorado.....	132	132	264	264
Connecticut.....	136	136	184	184
Delaware.....	130	100	184	184
District of Columbia.....	132	112	181	153
Florida.....	114	85	170	170
Georgia.....	93	84	151	151
Guam.....	120	120	161	161
Hawaii.....	122	122	191	191
Idaho.....	153	153	190	190
Illinois.....	176	176	221	221
Indiana.....	128	80	183	160
Iowa.....	122	113	186	172
Kansas.....	128	128	173	173
Kentucky.....	94	94	156	156
Louisiana.....	137	89	210	166
Maine.....	130	115	205	205
Maryland.....	91	91	124	124
Massachusetts.....	169	169	243	243
Michigan.....	156	156	198	198
Minnesota.....	143	143	196	196
Mississippi.....	120	65	184	130
Missouri.....	166	91	242	182
Montana.....	110	110	172	172
Nebraska.....	182	182	235	235
Nevada.....	165	165	264	264
New Hampshire.....	160	115	196	196
New Jersey.....	157	157	232	232
New Mexico.....	116	116	159	159
New York.....	162	162	234	234
North Carolina.....	108	108	132	132
North Dakota.....	147	140	190	180
Ohio.....	119	119	199	199
Oklahoma.....	122	122	206	206
Oregon.....	141	113	200	160
Pennsylvania.....	128	128	193	193
Puerto Rico.....	54	18	88	29
Rhode Island.....	163	163	211	211
South Carolina.....	87	80	121	121
South Dakota.....	145	138	189	189
Tennessee.....	102	97	142	142
Texas.....	115	115	184	184
Utah.....	76	76	122	122
Vermont.....	137	137	200	200
Virgin Islands.....	59	59	102	102
Virginia.....	138	138	179	179
Washington.....	192	192	247	247
West Virginia.....	146	76	186	97
Wisconsin.....	103	103	164	164
Wyoming.....	138	104	182	178

For aged single individuals who have no other income, this provision would result in increased assistance in about 31 States where monthly payments to such persons now range from \$65 to \$128. Aged couples would receive increased assistance payments in about 36 States.

Concurrently with establishing national minimum standards for assistance to the aged, blind, and disabled, the committee bill would also make persons receiving assistance under these programs ineligible to participate in the food stamp program. In effect, the committee bill would give needy persons more cash in lieu of food stamps.

Effective date—April 1, 1971.

PASS-ALONG OF SOCIAL SECURITY INCREASES TO WELFARE RECIPIENTS

(Sec. 502 of the bill)

Under the committee bill, social security benefits would be increased by 10 percent, with the minimum basic social security benefit increased to \$100 from its present \$64 level. If no modification were made in the present welfare law, however, many needy aged, blind, and disabled persons would get no benefit from these substantial increases in social security since offsetting reductions would be made in their welfare grants. For example, a needy aged individual in the State of Colorado is now eligible for a public assistance grant which will assure him a total monthly income of \$132. If he now gets the minimum social security benefit of \$64, his assistance grant would be \$68. If his social security benefit is raised to \$100, his welfare grant would be reduced to \$32 leaving him with the same total monthly income of \$132 and no net benefit from his social security increase. To assure that such individuals would enjoy at least some benefit from the social security increases, the committee bill requires States to raise their standards of need for those in the aged, blind, and disabled categories by \$10 per month for a single individual and \$15 per month for a couple. As a result of this provision, recipients of aid to the aged, blind, or disabled who are also social security beneficiaries would enjoy an increase in total monthly income of at least \$10 (\$15 in the case of a couple). Thus, in the above example, the needy aged individual in Colorado would have his welfare grant reduced by \$10 less than the increase he receives in social security. This would leave him with a total monthly income of \$142 as compared with his total income under present law of \$132.

Under the committee bill, all social security beneficiaries also receiving aid to the aged, blind, or disabled would be guaranteed an increase in total income of at least \$10 (\$15 for a couple). The social security pass-along provision would affect needy aged, blind, and disabled persons in States which now have standards of need in excess of \$120 for single individuals or \$185 for couples. Recipients in States with lower standards would receive an increase in total monthly income of at least \$10 (\$15 for a couple) as a result of the provision establishing national minimum standards of \$130 for aged, blind, or disabled individuals and \$200 for couples.

Effective date—April 1, 1971.

DEFINITIONS OF BLINDNESS AND DISABILITY

(Secs. 503 and 504 of the bill)

Under present law each State is free to prescribe its own definition of blindness and disability for purposes of eligibility for aid to the blind and aid to the permanently and totally disabled. The committee believes that the definition of these basic eligibility factors is a proper area for the establishment of nationally uniform standards. Accordingly, the committee bill makes applicable to these programs the definitions of blindness and disability which are used in the disability insurance program established under Title II of the Social Security Act.

The term "disability" would be defined by the committee bill as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." Under the disability insurance program, this definition is now found in section 223(d)(1) of the Social Security Act. The provisions of the disability insurance program further specify that this definition is met only if the disability is so severe that an individual "is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work." (Sec. 223(d)(2)(A).) This same test would apply in determining eligibility for welfare.

The term "blindness" would be defined as "central visual acuity of 20/200 or less in the better eye with the use of correcting lens." (Sec. 216(i)(1)(B).) Also included in this definition would be the particular sight limitation which is referred to as "tunnel vision."

The committee bill would permit States to continue assistance to disabled or blind individuals who are now on the rolls under the existing State definition, but who would not meet the Federal definition of blindness or disability.

Effective date—April 1, 1971.

AID TO THE BLIND—PROHIBITION OF LIENS

(Sec. 505 of the bill)

Under present law, States may at their discretion impose liens against the property of recipients of cash public assistance grants. The committee feels that it is inappropriate to require a blind individual to agree to a lien against his property in order to be eligible to receive welfare assistance. Accordingly, the committee bill would prohibit the imposition of such liens against the property of blind individuals as a condition of eligibility for aid to the blind.

Effective date—April 1, 1971.

FISCAL RELIEF FOR THE STATES

(Sec. 506 of the bill)

The committee is aware that the rapid growth of welfare expenditures in recent years has severely strained the fiscal capacities of the States, and feels that the States should not be made to bear the additional costs resulting from the improvements which the committee bill makes in the welfare programs for the aged, blind, and disabled. In particular, the committee notes that some of the States which are already among those making the greatest fiscal effort in these programs relative to per capita income would also be among the States required by this bill to make the largest increases in their levels of assistance. While a certain amount of fiscal relief will accrue to the States to the extent that welfare grants are reduced because of the increases which the bill provides in social security benefits, this relief is not necessarily distributed in a way which reflects the relative welfare burdens of the States under present law or under the additional requirements imposed by the bill.

The committee bill accordingly contains a provision to assure that with respect to aid for the aged, blind, and disabled all the additional expenditures required by the bill will be met without increasing State costs, and, furthermore, that the present State liabilities under these programs will be reduced. The bill provides that States in future years will not be required to spend more for assistance to the aged, blind, and disabled than 90 percent of their expenditures for this purpose in calendar year 1970. The 10 percent savings would be paid from Federal funds as would the full amount of any increased expenditures resulting from mandatory provisions of the bill (such as the \$10 pass-along of social security increases and the \$130 national minimum standard for assistance to the aged, blind, and disabled). Increases in caseloads resulting from normal program growth (for example, as a result of population increases) would also be fully paid for with Federal funds, but increased expenditures resulting from liberalizations in State welfare programs not required by Federal law would not be covered by the 90 percent limitation. The costs of any such non-mandatory program liberalizations would be shared by the Federal and State Governments in accordance with the regular matching provisions.

How this provision could work is illustrated in the following table.

Illustration of how committee bill could affect expenditures for aid to the aged, blind, and disabled in a hypothetical State

[In millions of dollars]

	Total	Federal		State	
		Present matching	Committee bill	Present matching	Committee bill
1970 costs-----	\$100	\$60	(¹)	\$40	(¹)
Costs in a future year:					
(a) Continuing present level--	100	60	94	40	36
(b) Normal program growth--	10	6		4	
(c) \$130 minimum; \$10 pass-along; other requirements of committee bill-----	20	12		8	
Total-----	130	78		52	36
(d) Growth from optional State program changes--	10	6	6	4	4
Total-----	140	84	100	56	40

¹ Not applicable.

In the hypothetical State described in the above table, total Federal-State expenditures for calendar year 1970 are \$100 million with the State now paying 40 percent (\$40 million) and the Federal Government paying 60 percent (\$60 million). In a future year, the costs of the program based on the continuation of present program levels could be \$100 million to which might be added a cost of \$10 million resulting from population increase and other normal program-growth factors, and a cost of \$20 million resulting from the social security pass-along, the national minimum standard of \$130 and other mandatory requirements of the committee bill. This would bring program costs for the year in question to a total of \$130 million. Under present matching provisions as applicable to this State, the Federal Government would pay 60 percent (\$78 million) and the State would pay 40 percent (\$52 million). The committee bill, however, would limit the State's share of these expenditures to \$36 million—90 percent of its 1970 expenditures of \$40 million. Thus, under the committee bill, the total program costs of \$130 million would be shared as follows: Federal share of \$94 million (72%); State share of \$36 million (28%). If, in the following year, total expenditures rose to \$150 million, the State's share would remain at \$36 million. (On a percentage basis, its share would drop to 24%).

If, however, a State raised its standards to more than the amount required by the \$10 social security pass-along provision or the \$130 national minimum, or if it made other program liberalizations not required by the committee bill, it would have to bear its full share of the extra costs resulting from such actions according to the regular Federal-State matching provisions. Thus, in the above example, if there were \$10 million of additional costs from optional State liberalizations, the State would be responsible for 40 percent of these costs—

\$4 million—which would be added to its \$36 million share of other program costs.

Effective date—April 1, 1971.

B. FEDERAL CHILD CARE CORPORATION

(Sec. 510 of the bill)

At the present time the lack of adequate child care represents perhaps the single greatest impediment to the efforts of poor families, especially those headed by a mother, to achieve economic independence.

The Committee on Finance has long been involved in issues relating to child care. The committee has been dealing with child care as a segment of the child welfare program of the Social Security Act since the original enactment of the legislation in 1935. Over the years, authorizations for child welfare funds were increased in legislation acted on by the committee.

A new emphasis began with the Public Welfare Amendments of 1962, in which the committee placed increased stress on child care services through a specific earmarking of child welfare funds for the provision of child care for working mothers. In the 1967 Social Security Amendments, the committee made what it believed to be a monumental commitment to the expansion of child care services as part of the work incentive program. Although the legislative hopes have not been met, and much less child care has been provided than was anticipated, it is a fact that child care provided under the Social Security Act constitutes the major Federal support for the care of children of working parents today. Through its support of child welfare legislation and programs, the committee has shown its interest, too, in the quality of care which children receive.

As part of its continuing concern for the welfare of families with children who are in need, the committee is proposing a new approach to the problem of expanding the supply of child care services and improving the quality of these services. The committee bill thus includes provision for the creation of a Federal Child Care Corporation, with the basic goal of making child care services available throughout the Nation to the extent they are needed. It is the committee's belief that this new and innovative approach to child care services can make a substantial impact on the Nation's problems of poverty and dependency.

NEED FOR CHILD CARE SERVICES

The need for child care resources is great and is growing, and it reflects the increasing participation of mothers in our Nation's labor force. The number of working mothers has increased more than seven times since 1940, and has more than doubled since 1950. There are, at the present time, approximately 13 million women with children under age 18 who are in the labor force. More than four million of these women have children under age 6.

Furthermore, the number of women workers is expected to grow rapidly in the years to come, and in fact is expected to increase faster

than the number of men workers. It is estimated that by 1980, the labor force will include more than 5 million mothers between the ages of 20 and 44 who have children under age 5. This would represent an increase of more than 40 percent in the number of such mothers just over the next decade.

We know that at the present time there are many mothers who would be working if they could arrange adequate care for their children. This is as true of mothers in low-income families as it is of middle-class mothers. A recent study of welfare mothers in New York City showed that seven out of 10 would prefer to work if they could find care for their children. Similarly, studies and statistics relating to the Work Incentive Program (WIN) for recipients of aid to families with dependent children have shown that lack of child care is a major impediment preventing mothers from participating in employment and training programs.

A recent study by the Department of Health, Education, and Welfare on the Aid to Families with Dependent Children program points out that in the 1960's the proportion of AFDC women with high employment potential increased from 25.3 percent in 1961 to 44.5 percent in 1968. The researcher, Perry Levinson, stated that "as the AFDC caseload grew ever larger between 1961 and 1968, recipients were more and more women who had stronger educational and occupational backgrounds, that is, high employment potential." However, over 80 percent of the women reportedly could not take jobs because they had children under 8 at home, while more than 50 percent lacked day-care facilities.

The facts and figures document the very great demand by parents at all economic levels for child care resources. Unfortunately, we can also document the very poor supply of resources available to meet this demand.

Recent statistics indicate that licensed child care facilities today can accommodate only between 600,000 and 700,000 children. That is, of course, only a fraction of the children who now need child care services. Many "latchkey children" are left with no supervision whatsoever; other children are placed in child care programs which do not even provide custodial care of adequate quality, much less the kind of care which would meet the child's individual needs for healthy development.

The committee is concerned that in spite of greatly increased willingness to pay for child care services by both governmental institutions and by private individuals, the supply of child care services is not increasing rapidly. In 1967, when the Congress established the Work Incentive Program, unlimited Federal matching funds were authorized for child care for mothers in work and training. Despite a Federal appropriation of \$25 million in fiscal year 1969, only \$4 million was actually used to purchase child care. In fiscal year 1970, \$52 million was appropriated but only \$18 million was used. The Department of Health, Education, and Welfare showed itself unable to utilize funds appropriated by the Congress to expand the availability of child care.

A major reason for this failure to utilize the funds available was the lack of administrative organization, initiative and know-how to create

and provide child care services, as well as barriers at the local level through licensing and other requirements. In other words, the present method of simply providing matching funds to the States and hoping that child care will become available is not working. It is not resulting in the necessary increase in supply.

The States themselves have had very limited resources to devote to child care, and for many of them child care services have been given a low priority. A number of State governments are not staffed to handle child care services, even on a minor scale. Many States which have established licensing requirements do not have the staff to constructively help organizations wishing to establish child care facilities to meet the licensing requirements.

In very few instances is there strong State initiative in promoting the development of child care resources. Private voluntary organizations by their own efforts alone are not capable of meeting the magnitude of need for child care services, however admirable a job they are able to do in individual instances. Local governments have shown themselves generally to be incapable of providing leadership in this area, and in many cases unnecessarily restrictive and complex local ordinances make it difficult for any group to establish a licensed child care facility.

Private enterprise has begun to move into the gap, and in some areas is doing an excellent job in providing needed child care. On its own, however, we cannot expect private enterprise to do the whole job of organizing and providing a wide range of child care services wherever they are needed in the Nation.

It is the committee's view that we need a new mechanism in facing this problem, a single organization which has both the responsibility and the capability of meeting this Nation's child care needs. It must be an organization which has the welfare of families and children at the forefront, an organization which, though national in scope, will be able to respond to individual needs and desires on the local level. It must be an organization which will be able both to make use of the child care resources which now exist and to promote the creation of new resources. It must be able to utilize the efforts of governmental agencies, private voluntary organizations, and private enterprise.

The new Federal Child Care Corporation, which would be created under the committee bill, is intended to be such an organization.

ESTABLISHMENT OF FEDERAL CHILD CARE CORPORATION

The basic goal of the Corporation would be to arrange for making child care services available throughout the Nation to the extent they are needed. As its first priority, the Corporation must provide services to present, past, and potential welfare recipients who need child care in order to undertake or continue employment or training.

To provide the Corporation with initial working capital, the Secretary of the Treasury would be required to lend the Corporation \$50 million as working capital, to be placed in a revolving fund. With these funds the Corporation would begin arranging for day care services. Initially, the Corporation would contract with existing public, nonprofit private, or proprietary facilities providing child care services. The Corporation would also provide technical assistance and ad-

vice to groups and organizations interested in setting up day care facilities under contractual relationship with the Corporation. The committee bill would in addition authorize the Corporation to provide child care services directly in its own facilities. It would be expected that services would be provided directly only where they are not otherwise available or where the quality of existing services is unacceptably low.

FINANCING CHILD CARE PROVIDED BY THE CORPORATION

The Corporation would have three sources of funds with which to operate:

1. A \$50 million loan from the Treasury to initiate a revolving fund;
2. Revenue bonds which could be sold to finance construction of facilities (this is discussed in more detail below), and
3. Fees paid for child care services.

Of the three, fees represent by far the most important source of funds.

The Corporation would charge fees for all child care services provided or arranged for; these fees would go into the revolving fund to provide capital for further development of child care services. The fees would have to be set at a reasonable level so that parents desiring to purchase child care can afford them; but the fees would have to be high enough to fully cover the Corporation's costs in arranging for the care.

It should be emphasized that the Federal Child Care Corporation which would be created under the committee bill would provide a mechanism for expanding the availability of child care services, but it would not itself provide funds for the subsidization of child care provided the children of low income working mothers. These costs would be met, as under present law, through the welfare programs, although the Federal share for child care costs would be raised from 75 percent to 90 percent (in certain cases, 100 percent). It would be expected that the Corporation would derive a major source of its funding from fees charged for child care provided the children of mothers on welfare.

In view of the past history, the committee anticipates that in most cases, welfare agencies will find it convenient to utilize the Corporation for the provision of child care services. However, the committee bill would not require them to do so.

If after its first 2 years the Corporation felt it needed funds for capital investment in the construction of new child care facilities or the remodeling of old ones, it would be authorized to issue bonds backed by its future fee collections. Up to \$50 million in bonds could be issued each year beginning with the third year after the Corporation's establishment, with an overall limit of \$250 million on bonds outstanding.

The committee bill is carefully designed so that the Corporation's operations and capital expenditures over the long run would not cost the taxpayers a penny. The Corporation would pay interest on the initial \$50 million loan from the Treasury, interest which each year would match the average interest paid by the Treasury on its borrowings. The Corporation would further be required to amortize the loan

over a 25-year period by paying back principal at the rate of \$2 million annually. Finally, the Corporation's capital bonds would be sold directly to the public and would not be guaranteed by the Government, but only by the future revenues of the Corporation.

KINDS OF CHILD CARE OFFERED

From the standpoint of parents, the Corporation would provide a convenient source of all kinds of child care services, at reasonable fees. Like the Social Security Administration, the Corporation eventually would maintain offices in all larger communities of the Nation, where parents desiring child care services would be able to obtain them through the Corporation either directly in Corporation facilities or in facilities under contract with the Corporation. In either case, the parents could be confident that the child care services were under the supervision of the Corporation and met the standards set forth in the bill.

The bill would require the Corporation to make available a wide variety of child care services, some already well known and some unavailable in most places today. For example:

Parents primarily interested in an intensive educational experience for their preschool-age children would be able to send their children to nursery schools, kindergartens (where these are not already provided by the school system), or child development centers such as those under the Headstart program.

Parents seeking full-day child care in a facility offering a balanced program of education and recreation for preschool-age children would be able to send their children to a child care center.

Parents wishing to have their preschool-age child cared for in a home setting among a small group of children under the supervision of a trained adult would be able to select a family day care home.

Parents of school-age children would be able to choose a facility whose hours and programs were patterned to complement the child's day in school. School-age child care could take the form of a recreational program run by the school itself, or it could be offered, like preschool-age child care, in a center or under trained adult supervision in a home.

Parents seeking child care during the summer vacation would be able to send their children to day camps or summer camps.

The Corporation would be required to establish temporary or drop-in child care facilities for the parent who requires child care services from time to time while taking courses at a school or university, shopping, or otherwise engaged.

The Corporation would be required to arrange for at-home child care, or babysitting. This would enable a parent to continue at work if the child became sick or had a brief school vacation. It would also assure the parent of the availability of babysitting during the day as well as in the evening when the parent was absent.

Parents requiring child care services regularly at night would be able to send them to night care facilities, primarily designed to care for the child during sleeping hours. Nurses, maintenance

staff, and persons in other nighttime jobs now find it almost impossible to arrange for child care services while they work.

Parents requiring care for their children 24 hours a day for less than a month would be able to arrange for the care at a boarding facility. This kind of facility, which could be a summer camp, would provide care if the parents planned to be away for a weekend or for a vacation. If a welfare agency were purchasing care on the child's behalf, provision could be made for a disadvantaged child in a city to be sent to summer camp.

ESTABLISHING NEW CHILD CARE FACILITIES

The Corporation will depend for its success in expanding the availability of child care services on the efforts of public and private groups at the local level in establishing child care facilities. It is the committee's hope that local parent groups, churches, and other organizations will be stimulated to establish child care facilities. Today, such groups must go through cumbersome administrative procedures to establish a child care facility, if indeed they are able to establish one at all.

Under the committee bill, they would merely need to contract with the Corporation for the provision of child care services. If the Corporation is assured that the group can fulfill its commitment, the group will be able to receive advance funding to begin operations. Moreover, certification by the Corporation will replace the present time-consuming approvals required from various agencies at the local level.

If the Corporation is in particular need of child care facilities in an area and facilities exist but are of low quality, the Corporation might contract with the understanding that the facility will be improved. If the promised improvement does not take place, the Corporation would be expected to provide child care services directly in the future rather than to continue to contract for services of unacceptable quality.

Child care services organized by parents or run with extensive parent participation have shown great promise in raising the educational level of disadvantaged children in deprived areas. Groups interested in promoting parent involvement should find it possible to establish child care facilities through the Corporation where they are unable to do so today.

TRAINING OF CHILD CARE PERSONNEL

The committee regrets that lack of trained personnel has hampered efforts to expand child care services in the past. It is clear that the purpose of establishing the Federal Child Care Corporation will be frustrated if this situation is not changed. Authority already exists under section 426 of the Social Security Act for the training of personnel in the child care field. It is the committee's intention that sufficient funding be sought under this authority to greatly expand child care personnel.

In addition, the committee feels that many mothers receiving Aid to Families with Dependent Children have both the inclination and the ability to provide child care for other children. It is the committee's intention that welfare mothers and other women in low-income neighborhoods where the need for child care services is greatest be

given the highest possible priority in training additional child care personnel. It is with this goal in mind that the committee bill would direct the Secretary of Labor to utilize the Work Incentive Program to the maximum extent in providing training for welfare recipients to become proficient in child care.

In addition, the Corporation is authorized to conduct (either directly or by contract) in-service training programs to prepare individuals in the child care field. It is the committee's hope that these provisions will enable the Corporation to accomplish two aims at once—ending the dependency of some welfare recipients by providing opportunities in child care, and expanding child care services so that other mothers on welfare may have an opportunity for employment.

CONSTRUCTION OF CHILD CARE FACILITIES

It is the committee's view that child care services can be greatly expanded through the utilization of existing facilities not now used during the week. Schools often are not used after school hours, churches and Sunday schools are frequently available during the week. Apartment houses, public housing units, office buildings and even factories can serve as convenient child care locations, though they are seldom so used today. The committee bill provides authority for the Corporation to issue revenue bonds for capital construction costs, but it is the committee's intention that construction be resorted to only when child care services may not otherwise be provided. With the provisions of the bill discussed below, enabling facilities arranged for through the Corporation to be safe while avoiding unnecessarily stringent local building codes, it should be possible to expand facilities with only sparing resort to the construction authority.

CHILD CARE STANDARDS

As has been noted, of the millions of children who are not cared for by their parents during the day, well under 1 million receive care in licensed child care facilities. One of the major goals of the committee bill is to insure that the facilities providing care under the Corporation's auspices meet national child care quality standards which are set forth in the bill.

When Dr. Edward Zigler, the head of the Office of Child Development in the Department of Health, Education, and Welfare, was before the Committee for hearings on his confirmation, he was asked if he agreed that it was unnecessarily difficult to set up a licensed child care facility in a large city. Dr. Zigler replied:

I think it is probably true that there have been so many demands placed on both profit and non-profit groups that in certain instances it is becoming ridiculous because there is overlapping responsibility on the part of local people, State people, and so forth. I think if we are serious about setting up a worthwhile social institution such as day care for working mothers we may have to develop guidelines at a national level which would have some nationwide application. It would be a standard process because now it is too difficult and it is too rigid, and I am very much afraid the professionals have overdone themselves here.

They have bent so far backwards in protecting the physical welfare at the expense of psychological wellbeing that I do not find myself in great sympathy with some of the statutes.

As Dr. Zigler points out, overly rigid licensing requirements in general have relegated children to unsupervised and unlicensed care, if indeed any care, while their parents work.

The problem is highlighted in a recent report entitled "Day Care Centers—The Case for Prompt Expansion," which explains why day care facilities and programs in New York City have lagged greatly behind the demand for them:

The City's Health Code governs all aspects of day care center operations and activities. Few sections of the Code are more detailed and complex than those which set forth standards for day care centers. The applicable sections are extremely detailed, contain over 7,000 words of text and an equal volume of footnotes, and stretch over two articles and twenty printed pages.

The provisions of the City's Health Code that apply to day care center facilities constitute the greatest single obstacle to development of new day care center facilities. The highly detailed, and sometimes very difficult-to-meet, specifications for day care facilities inhibit the development of new facilities. Obviously there must be certain minimum fire, health, and safety standards for the protection of children in day care centers. The provisions of the Health Code go far beyond this point. Indeed, some sections of the Code are a welter of complex detail that encourages inflexibility in interpretation and discourages compliance.

Section 45.11(i) of the Health Code, for example, reads: "Toilets shall be provided convenient to playrooms, classrooms and dormitories and the number of such toilets shall be prescribed by section 47.13 for a day care service, 49.07 for a school, or 51.09 for a children's institution. In a lavatory for boys six years of age and over, urinals may be substituted for not more than one-third of the number of toilets required. When such substitution is made, one urinal shall replace one toilet so that the total number of toilets and urinals shall in no case be less than the number of required toilets. Toilets and urinals shall be of such height and size as to be usable by the children without assistance."

Subsection 6 of Section 45.11 of the Health Code is another example. It prescribes lighting standards for day care centers, as follows:

- (1) Fifty foot candles of light in drafting, typing, or sewing rooms and in all classrooms used for partially sighted children;
- (2) Thirty foot candles of light in all other classrooms, study halls or libraries;
- (3) Twenty foot candles of light in recreation rooms;
- (4) Ten foot candles of light in auditoriums, cafeterias, locker rooms, washrooms, corridors containing lockers; and
- (5) Five foot candles of light in open corridors and store rooms.

Legally, only those centers that conform to the Health Code may be licensed. Faced with Health Code requirements of such detail, personnel of the Divisions concerned in the Department of Health and in the Department of Social Services have had to choose between considering the regulations as prerequisites to

the licensing of new day care centers or merely as goals toward which to work.

In general, the choice is made in favor of strict interpretation notwithstanding the fact that this severely handicaps the efforts of groups attempting to form centers in substandard areas.

The bill includes standards requiring child care facilities to have adequate space, adequate staffing, and adequate health requirements. It avoids overly rigid requirements, in order to allow the Corporation the maximum amount of discretion in evaluating the suitability of an individual facility. The Corporation will have to assure the adequacy of each facility in the context of its location, the type of care provided by the facility, and the age group served by it.

To assure the physical safety of children, the bill requires that facilities must meet the Life Safety Code of the National Fire Protection Association. This will provide protection for those many children today who are being cared for in unlicensed facilities, the safety of which is unknown.

Any facility in which child care was provided by the Corporation, whether directly or under contract, would have to meet the Federal standards in the law, but it would not be subject to any licensing or other requirements imposed by States or localities. This provision would make it possible for many groups and organizations to establish child care facilities under contract with the Corporation where they cannot now do so because of overly rigid State and local requirements. From the standpoint of the group or individual wishing to establish the facility, this provision would end an administrative nightmare. Today, it can take months to obtain a license for even a perfect child care facility, by the time clearance is obtained from agency after agency at the local level. Under the bill, persons and groups wishing to establish a child care facility would be able to obtain technical assistance from the Corporation; they would have to meet the Federal standards and they would have to be willing to accept children whose fees were partially or wholly paid from Federal funds, in order to contract with the Corporation.

REPORTING REQUIREMENT

The bill requires the Corporation to submit a report to each Congress on the activities of the Corporation, including data and information necessary to apprise the Congress of the actions taken to improve the quality of child care services and plans for future improvement.

BOARD OF DIRECTORS

The Corporation would be headed by a Board of Directors consisting of three members, to be appointed by the President with the consent of the Senate. The members of the Board would hold office for a term of three years.

NATIONAL ADVISORY COUNCIL

A National Advisory Council on Child Care would be established to provide advice and recommendations to the Board on matters of

general policy and with respect to improvements in the administration of the Corporation. The Council would be composed of the Secretary of Health, Education, and Welfare, the Secretary of Labor, the Secretary of Housing and Urban Development, and 12 individuals (nine of them representative of consumers of child care), appointed by the Board.

INCREASE IN FEDERAL MATCHING FOR CHILD CARE SERVICES

Under present law, child care for the children of working mothers who receive public assistance may be paid for in one of two ways:

1. The child care may be arranged by the welfare agency, which would pay for the care and receive 75 percent Federal matching; or

2. A mother may arrange for child care herself and in effect be reimbursed by adding the cost of child care to her welfare payment as a work expense.

According to the Auerbach Corporation, an organization that studied the Work Incentive Program, the latter method has by far been the more common:

Our own findings raise even more doubts about the extent to which WIN mothers may be benefiting themselves and their families through WIN. In the cities selected for the child care studies, slightly over two hundred mothers were interviewed to determine their need for child care, what they were told about child care, and how it was obtained. Our results show that not only did the overwhelming majority (eighty-eight percent) arrange their own plans, independent of welfare, but that most (eighty percent) were informed by their caseworkers that it was their responsibility to do so. Even more discouraging is that the majority of mothers (eighty-three percent) who were informed about child care by their caseworkers were left with the impression that they could make use of any service they wanted; approved services were not required.

This situation is reflected in the inability in the Department of Health, Education, and Welfare to use all the funds appropriated by the Congress for child care under the Work Incentive Program.

The committee bill would increase the Federal matching percentage for child care services under the AFDC program from 75 percent to 90 percent, with the Secretary of Health, Education, and Welfare authorized to waive the requirement of 10 percent non-Federal funds for a limited period of time when this is necessary in order for any child care services to be available. States would be required to maintain their present level of expenditures for child care services so that the additional Federal funds would not simply replace State funds.

Under present law, Federal matching is provided for all individuals who need child care services in order to participate in employment or training under the Work Incentive Program, and States are required to make such services available. States may, at their option, provide services for other past, present, or potential recipients of welfare. The committee bill retains these provisions, and 90 percent Federal matching would be available to provide services in all of these circumstances.

C. IMPROVEMENTS IN THE WORK INCENTIVE PROGRAM

(Sec. 520 of the bill)

The Work Incentive Program was created by the Congress as a part of the Social Security Amendments of 1967. It represents an attempt to cope with the problem of rapidly growing dependency on welfare by providing recipients with the training and job opportunities needed to help them become economically independent.

The Committee on Finance was a principal architect of the WIN program and was responsible for the basic decision that the Department of Labor would administer the manpower training program. However, the committee has been greatly disappointed in the administrative implementation of WIN. The Auerbach Corporation, the Labor Department's prime evaluator of WIN, succinctly sums up the situation:

"Despite the program's timeliness and general conceptual soundness, it has not lived up to expectations."

The points of emphasis the committee thought were abundantly clear in the 1967 amendments have been paid lip service or have been totally ignored. A meaningful program of on-the-job training continues to be an unfulfilled Labor Department promise. The legally required program of special work projects (public service employment) is a reality in only one State. Lack of Labor Department and Health, Education, and Welfare cooperation and that of their counterparts at the local level has been a major problem in the referral process and in the provision of necessary supportive services for recipients in work and training. The main thrust of the WIN program as it exists today remains in the direction of basic education and classroom training, which our experience with manpower training over the last decade shows not to result in the placement of people in jobs, but rather in a growing skepticism of both welfare recipients and the public as to the worth of such endeavors.

The committee's amendments to the Work Incentive Program are designed to make even clearer and more effective what it intended in 1967, and to add certain tax credit mechanisms which will effectively link manpower training with the actual provision of jobs.

STATUS OF THE WORK INCENTIVE PROGRAM

It has been characteristic of the Work Incentive Program that stated expectations and actual results have diverged widely. The Department of Labor estimates to the House-Senate conferees in 1967 included a projection that in fiscal year 1970, the first full year of the WIN program, there would be 150,000 trainees. In 1969, the estimate to the Appropriations Committee of the number of trainees in 1970 was cut approximately in half—to a total of 77,000 trainees. The actual average number of trainees in 1970 was 42,000—less than one-third of the projection given the Congress when the program was established.

The Department of Labor spokesman told the Appropriations Committee in the fall of 1969 that there would be 150,000 enrollees actually in the program by July 1970. Later in the fiscal year they told the Committee on Ways and Means and this committee that 100,000

enrollees would be in the program by July 1970. Actually, by this date there were only 89,689 enrollees and by the first of October 1970, this figure had only increased to 97,238. What is more significant, however, is that almost 30,000 of these enrollees are either waiting for training to begin, waiting between training components, or have completed their training but have not been placed in jobs. This latter category has nearly doubled between July and October of this year, and there are now 4,500 WIN participants who have completed training but are waiting for jobs. Of the approximately 68,000 WIN participants actually involved in training on October 1, almost 50,000 of them are either in orientation, basic education, or classroom vocational training—training with little relationship to actual work experience.

ON-THE-JOB TRAINING AND PUBLIC SERVICE EMPLOYMENT

A major criticism of the present Work Incentive Program has been the lack of development of on-the-job training and public service employment (special work projects). These components offer the best opportunity for the employment of welfare recipients because they provide training in actual job situations. Unfortunately, only about 1.8 percent of the welfare recipients enrolled in WIN are participating in on-the-job training and public service employment.

The Auerbach Corporation, in its report on the WIN program, made the following comment on OJT:

The majority of training courses for WIN are institutional. Though these have been supplemented by individual contracts, a pressing need exists for on-the-job training. In most areas, including some of the largest programs visited, no OJT courses for WIN enrollees have been procured. For example, the largest program evaluated has staff dedicated to the development of OJT slots. After seven months no results have been produced. The main reason for this is the competition for the limited number of OJT slots among many agencies and programs. In some areas, the private sector has been saturated. The Work Incentive Program finds itself further limited since its contracting provisions are not competitive with National Alliance of Businessmen (NAB) OJT under the MA-4 Contracting provisions. The MA-4 contracts, moreover, are usually unavailable to WIN applicants since the Concentrated Employment Program (CEP) is the prime deliverer of manpower to NAB and can fill the slots from its own applicants.

In many respects, OJT is the most desirable of all training options, since it screens for a job at the beginning rather than at the end of training. The applicants are aware when they are placed in OJT that this is already a job and that they have a position if they can hold it. Unlike Institutional Training, which does not guarantee a placement (and many applicants express the fear that they will not get a job), OJT has the incentive of employment built in.

Although these observations as to the development of OJT were made during a period of a higher level of employment and economic activity than exists today, the committee believes that with increased

efforts of Federal and State personnel and the use of the tax credit mechanism discussed in the next section, OJT can become an important part of WIN. The committee also believes that the Department of Labor and the local manpower agencies should give the highest priority to obtaining OJT slots for WIN participants.

The need for a substantial program of public service employment was clearly recognized and made mandatory by this committee in 1967. The legislation put an obligation on the Secretary of Labor to establish as part of each WIN program a program of special work projects for individuals for whom a job in the regular economy cannot be found. Since that time the need for this type of program has become increasingly apparent but this fact has only belatedly been recognized in principle by the Executive Branch.

To remedy this lack of emphasis in the WIN Program, the committee's amendment would require that at least 40 percent of the funds spent for the Work Incentive Program be used for on-the-job training and public service employment (which replaces the special work projects of the current WIN program). Moreover, the committee's bill would simplify the financing and increase the Federal share of the cost of public service employment by providing 100 percent Federal funding for the first year, and 90 percent Federal sharing of the cost in subsequent years. If the project was in effect less than three years, Federal sharing for the first year would be cut back to 90 percent. The safeguards on special work projects under existing law relating to health, safety, and other working conditions are continued for public service employment, as well as the provision that no wages "shall be lower than the applicable minimum wage for the particular work concerned."

As under the special work projects of existing law, the persons under public service employment will be reviewed every 6 months for possible placement in private employment.

Effective date—July 1, 1971.

TAX INCENTIVE FOR HIRING WIN PARTICIPANTS

As an incentive for employers in the private sector to hire individuals placed in on-the-job training or employment through the Work Incentive Program, the committee amendment would provide a tax credit equal to 20 percent of the wages and salaries of these individuals. The credit would only apply to wages paid to these employees during their first 12 months of employment, and it would be recaptured if the employer terminated employment of an individual during the first 12 months of his employment or before the end of the following 12 months. This recapture provision would not apply if the employee became disabled or left work voluntarily. This provision will constitute an important link between training and jobs.

The tax credit is described more fully in Part X of this report.

LACK OF RELATION BETWEEN TRAINING PROGRAM AND LOCAL LABOR MARKET NEEDS

The Auerbach Corporation stated in its report :

Much more needs to be known about the actual availability of jobs for WIN "graduates" in areas where the program

functions. Analysis should be made, on a site-by-site basis, and should include both job opportunities which are extant and those which are expected to be developed. A particular area of inquiry is the relative potential of the public and private sectors of the economy to supply jobs. WIN operates in many areas on the assumption that large numbers of jobs can be readily secured in the private sector; this assumption may not be borne out by investigation.

Once the potential job market for WIN enrollees is defined, the program should be planned around that market, in terms of both slot allocation and provision of components. The size of WIN projects is presently determined by the size of the local AFDC population: it would make more sense to let project size be governed by actual job availability. Labor market analysis would also ensure that training programs were suitable for existing jobs.

To meet the existing unmet need for labor market analysis, the committee bill would require the Secretary of Labor to establish local labor market advisory councils whose function would be to identify present and future local labor market needs. The bill provides that if there is already an appropriate body in an area, the Secretary of Labor may designate it as the advisory council. The findings of this council would have to serve as the basis for local training plans under the Work Incentive Program to assure that training was related to actual labor market demands.

Effective date—July 1, 1971.

REGISTRATION OF WELFARE RECIPIENTS AND REFERRAL FOR WORK AND TRAINING

Under present law, all "appropriate" welfare recipients must be referred by the welfare agency to the Labor Department for participation in the Work Incentive Program. Certain categories of persons are statutorily considered inappropriate. Persons may volunteer to participate in the Work Incentive Program even if the State welfare agency finds them inappropriate for mandatory referral.

A major criticism of the program has been that the State application of those standards of "appropriateness" for the program have resulted in widely differing rates of referrals and program participation. The committee's bill would eliminate this situation with a series of amendments. First, it would require welfare recipients to register with the Labor Department as a condition of welfare eligibility unless they fit within one of the following categories:

1. Children who are under age 16 or attending school;
2. Persons who are ill, incapacitated or of advanced age;
3. Persons so remote from a WIN project that their effective participation is precluded;
4. Persons whose presence in the home is required because of illness or incapacity of another member of the household; and
5. Mothers with children of preschool age.

At least 15 percent of the registrants in each State would be required to be prepared by the welfare agency for training and referred to the Work Incentive Program each year. States failing to meet this per-

centage would be subject to a decrease in Federal matching funds for aid to families with dependent children. Under the bill the Federal matching percentage for AFDC assistance payments would be reduced by one percentage point for each percentage point the State fell below the 15 percent requirement for referral of registrants. The committee emphasizes the point that the only referrals of welfare recipients which meet the 15 percent requirement are those made after adequate assessment of training and employment potential together with the provision of the day care, social and medical services which are necessary for their effective participation in WIN. "Paper referrals" by the welfare agencies in some States have been one of the problems of WIN and such referrals would not meet the requirement of this provision.

The committee bill would also establish clear statutory direction in determining which individuals would receive employment or training by generally requiring the Departments of Labor and Health, Education, and Welfare to accord priority in the following order, taking into account employability potential:

1. Unemployed fathers;
2. Dependent children and relatives age 16 or over who are not in school, working or in training;
3. Mothers who volunteer for participation; and
4. All other persons.

Thus, under the amendment, mothers would not be required to participate until every person who volunteered was first placed.

Effective date—July 1, 1971.

ALLOWANCES FOR TRANSPORTATION AND OTHER EXPENSES NECESSARY TO TRAINING

Another of the problems of the WIN program has been reimbursement for training expenses which, under existing law, must come from the welfare side of the program. This has often resulted in delayed payments, multiple checks and general inconvenience to the trainee which have had an adverse effect on his attitude toward the program. Under the committee's bill the local manpower agency could reimburse the trainee for necessary expenses directly related to his participation in training, such as transportation, lunches, special clothes, and supplies needed for the training.

Effective date—January 1, 1971.

PROGRAM COORDINATION ON THE FEDERAL LEVEL

The successful administration of the entire referral process requires the careful coordination of efforts by both the Labor Department and HEW and their agencies at all levels of Government. This requirement has not always been met in the operation of the current WIN program. The Auerbach report observes:

Though the success of WIN depends on a coordinated activity, it has been largely carried out as two separate programs. Separate guidelines—not always in agreement—have been issued by Departments of Labor and Health, Education and Welfare, and few joint procedures or training packages

have been promulgated. The result has been a misunderstanding between local welfare and manpower agencies since there has been little interagency liaison and little information in either agency about the other's responsibility or activities. In particular, caseworkers—who are responsible for many of the WIN services—often know little about the WIN responsibilities of the welfare agency, much less about those for the Employment Service.

The committee bill meets this problem by mandating coordination between the Departments of Labor and Health, Education, and Welfare on the national, regional, and local levels. It requires that all regulations on the Work Incentive Program be issued jointly by both Federal agencies within six months of enactment. It also requires that a joint Health, Education, and Welfare-Labor Committee be set up to assure that forms, reports, and other matters are handled consistently between the two departments. The Auerbach report cited as imperative the need that the Work Incentive Program be operated under one set of guidelines, policies, and administrative procedures—a situation found not to be the case today.

PROGRAM COORDINATION AT THE LOCAL LEVEL

Under present law, the welfare agency is supposed to prepare an employability plan for each appropriate welfare recipient and make referrals to the Department of Labor. The Department of Labor is then to prepare an employability plan and place the individual in employment, on-the-job training, institutional training, or public service employment (special work projects).

Problems have arisen in this process. In some cases, the welfare agency has not referred sufficient numbers of persons, while in other cases they have referred far too many persons, without first arranging for the supportive services (such as child care or remedial medical services) needed in order to enable the welfare recipient to participate in the Work Incentive Program. The large number of persons who are enrolled in the WIN program but are forced merely to wait for training or placement, attest to the lack of planning and coordination in the present process.

The more dynamic WIN jurisdictions have established separate administrative units in their welfare agencies, with the sole responsibility of seeing that WIN trainees are afforded the medical, social, and vocational rehabilitation services necessary to their effective participation in the program. The committee bill would require that all States set up such separate units. To help implement this provision, expenditures related directly to the services provided by these units will generally be matched by the Federal Government at the 90 percent level under the committee bill. Under present law, the Federal matching for these services is generally at 75 percent (but may be as low as 50%) and must compete with other social and medical services not related to the employment program. Furthermore, the bill would require that the welfare agency and the Labor Department on the local level enter into a joint agreement on an operational plan—that is, a

plan setting forth the kinds of training they would arrange for, the kinds of job development the Labor Department would undertake, and the kinds of job opportunities for which both agencies would need to prepare persons during the period covered by the plan. In addition, both agencies would jointly develop employability plans for individuals, consistent with the overall operational plans, to assure that individuals receive the necessary supportive services and preparation for employment without unnecessary waiting. Recipients may be consulted during the development of their employability plans, but they will not be allowed to veto a plan which is developed for them.

Effective date—July 1, 1971.

WIN STAFFING PROBLEM

Relying on the report of the Auerbach Corporation, the Department of Labor notes the problem that the application of State civil service laws has had on the effective staffing of WIN projects. The Labor Department WIN report transmitted to the Congress in July 1970 states:

Staffing WIN projects was hampered by civil service procedures in many States. Seniority provisions in State merit systems often required that persons in the employment service agencies with seniority be given preference for positions needed to staff the new programs, even though they might be poorly suited to work with welfare recipients. This problem was particularly acute at the management supervisory levels.

Existing job descriptions, lists, and qualifications indices did not facilitate recruitment of the kind of staff who could work with disadvantaged persons. Where the selection criteria were not changed, the new employees were not what the program really needed. For example, qualifications for counselor positions in most States require a college degree with credits in a behavioral science. Such academic background, however, does not insure that the graduate will be able to handle vocational problems, work with disadvantaged minority group applicants, and understand the lifestyle and outlook of the poor. In addition, turnover is encouraged by low salary levels, particularly among counselors with a few years' experience who can find more lucrative positions elsewhere.

The committee notes that inasmuch as responsibility for administering WIN is delegated in the statute specifically to the Secretary of Labor, he currently has authority to overcome these impediments to effective WIN administration.

ALLOCATION OF FEDERAL FUNDS AND INCREASED FEDERAL MATCHING

Under existing law, there is no method of allotment of Federal funds to the States for WIN programs. The committee bill would provide that funds for the program be allocated among the States on the basis of the number of registrants for work and training. This would give

States some advance knowledge of their entitlement for training slots under the Work Incentive Program.

One of the reasons stated by the Department of Labor for the slow implementation of WIN in some States is the current Federal matching share for training expenditures of 80%. The committee bill endorses the Administration's proposal to raise the Federal matching share to 90%. This should go far in removing any financial impediment to State participation in WIN.

Effective date—July 1, 1971.

COORDINATION WITH OTHER MANPOWER PROGRAMS

The committee bill would require that the Secretary of Labor utilize other existing manpower programs to the maximum extent feasible, to avoid unnecessary duplication of programs. This continues a similar provision of existing law. Under this provision, as under existing law, the committee expects that WIN participants will be placed in programs—such as JOBS—established under other statutes. WIN funds are available for these costs, and the committee does not wish separate programs established for WIN participants where these people can be served by already-established manpower programs. The committee expects that WIN participants will be given the priority appropriate to their situation as being the most disadvantaged citizens of our nation.

TECHNICAL ASSISTANCE

Under existing law there appears to be a question of whether the Secretary of Labor is authorized to provide technical assistance to local manpower agencies in establishing and carrying on WIN projects. The committee's bill includes a provision giving the Secretary this specific authority, thus clarifying the matter.

Effective date—January 1, 1971.

INFORMATION ON WIN

The committee bill would require the Secretary of Labor to collect significant statistical information on the Work Incentive Program so that progress under the program can be better evaluated.

Specifically, as part of his overall information gathering responsibilities, the Secretary of Labor shall publish monthly the following information on WIN participants, by age group and sex:

1. The number of individuals registered with the Labor Department, the number of individuals receiving each particular type of work training services, and the number of individuals receiving no such services;

2. The number of individuals placed in jobs by the Secretary under the program, and the average wages of the individuals so placed;

3. The number of individuals who begin with but fail to complete training, and the reasons for the failure of such individuals to complete training; and the number of individuals who register voluntarily but do not receive training or placement;

4. The number of individuals who obtain employment following the completion of training, and the number of such individuals whose employment is in fields related to the particular type of training received;

5. Of the individuals who obtain employment following the completion of training, the average wages of such individuals, the number retaining such employment 3 months, 6 months, and 12 months following the date of completion of such training;

6. The number of individuals in public service employment, by type of employment, and the average wages of such individuals; and

7. The amount of savings, realized by reason of the operation of each of the programs established pursuant to this part.

Effective date—July 1, 1971.

EARNED INCOME DISREGARD

Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard the first \$30 earned monthly by an adult plus one-third of additional earnings. Costs related to work (such as transportation costs) are also deducted from earnings in calculating the amount of the welfare benefit.

Two problems have been raised concerning the earned income disregard under present law. First, Federal law neither defines nor limits what may be considered a work-related expense, and this has led to great variation among States and to some cases of abuse. Secondly, some States have complained that the lack of an upper limit on the earned income disregard has the effect of keeping people on welfare even after they are working full-time at wages well above the poverty line.

The committee bill would deal with both of these problems by modifying the earnings disregard formula and by allowing only day care as a separate deductible work expense (with reasonable limitations on the amount allowable for day care expenses). Under the committee bill, States would be required to disregard the first \$60 earned monthly by an individual working full-time (\$30 in the case of an individual working part time) plus one-third of the next \$300 earned plus one-fifth of amounts earned above this. This differential between full time and part time employment is designed to encourage those who are able to move into full time jobs.

Effective date—July 1, 1971, except that States may adopt this change earlier at their option.

CONCLUSION

The task of training welfare recipients for jobs and actually placing them in employment on a permanent basis is admittedly one of the most difficult tasks facing government. The committee believes that the changes it is proposing for WIN are important, albeit some of these could have been made without changes in the statute. But the committee is also aware that regardless of what the Congress does in this area the ultimate success of the program will, in large measure, be dependent on the dedication of administrators at the Federal, State,

and local level and the resources they are allocated. The committee believes it is incumbent upon the Department of Labor to show its commitment to WIN and to provide sufficient staffing at the Federal level commensurate with its responsibilities as the primary administrator of the program. The WIN program must receive the kind of implementation its importance deserves.

D. FAMILY PLANNING SERVICES

(Sec. 520(a) (9) of the bill)

The committee bill provides for a major advance in enabling the poor to obtain free family planning services by authorizing 100 percent Federal funding for State family planning programs for present and potential welfare recipients, including both information and the provision of medical services.

As under present law, States would be required to offer family planning services to all appropriate recipients of Aid to Families with Dependent Children. The committee's amendment would also allow the States to receive 100 percent Federal funding for programs for both former recipients and those who are likely to become recipients of welfare. Acceptance of services, as under present law, would be voluntary with the recipient.

The committee believes that its amendments will give great impetus to the development of family planning services by the States. A beginning has been made as the result of congressional action in 1967, when provisions were included in the Social Security Amendments which required that family planning services be offered all appropriate AFDC recipients, and authorized 75 percent Federal matching funds for this purpose. The same matching was also made available to the States on an optional basis for services for former or potential recipients of welfare.

The progress which has been made under the 1967 Amendments, however, has not met the committee's expectations. The annual report by the Department of Health, Education, and Welfare covering family planning services includes information which makes clear that the mandate of the Congress that *all* appropriate AFDC recipients be provided family planning services has not been fulfilled. The report states:

Many problems, of course, remain. Medical services [family planning] still are too limited, especially in rural areas but frequently in large urban areas as well. Replying to the question whether medical family planning programs currently available are adequate to meet the needs of eligible clients, 36 State welfare agencies answered in the negative in March, 1970. Thirty-one cited geographic inaccessibility as a major problem. Many reported a shortage of health professionals and paraprofessionals and some reported that existing facilities are overcrowded. Even in the Nation's principal counties and cities where clinics are more likely to be found than in less populous sections, 50 out of 106 local welfare agencies reported that currently available medical planning programs are inadequate.

Looking at their own capability of providing family planning services, many State and local welfare agencies report a shortage of staff to provide services and to arrange for adequate follow-up. Training programs for staff have not been mounted on the scale required. Although Federal funds may be used to match \$3 for every \$1 spent from State funds for services, time and again agencies emphasize the difficulty of raising the 25 percent share at State and local levels. Generally, no special funds have been made available to develop family planning services, as indicated, for example, by the general absence of full-time staff leadership for this program. Expectations among some groups that title IV funds would be available to reach substantial numbers of low-income families not currently receiving welfare have not been realized. . . .

Testimony presented during the hearings has persuaded the committee that the 75 percent Federal matching percentage, although a major step in promoting family planning services, has not been sufficient to achieve the aims of the committee. By providing 100 percent Federal funding, the committee bill will remove any existing financial barrier.

The committee believes its amendment is consistent with the aims of the Administration, as expressed by the President in a speech in July 1969:

Most of an estimated five million low income women of childbearing age in this country do not have adequate access to family planning assistance, even though their wishes concerning family size are usually the same as those of parents of higher income groups.

It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do.

The committee shares the goal of the President. It notes that, according to testimony of Planned Parenthood Federation, full family planning services can be provided for about \$60 per woman per year. This seems a small price to pay for the personal, social and economic benefits which can be achieved as the result of an effective nationwide family planning program.

Effective date—January 1, 1971.

E. EMERGENCY ASSISTANCE FOR MIGRANT FAMILIES WITH CHILDREN

(Sec. 530 of the bill)

Under existing law, emergency assistance may, at the option of the States, be provided to needy migrant families and be provided either Statewide or in part of the State. The committee believes that there is an urgent need to assist these families and children and that this

problem is of a national nature. Therefore, the committee bill amends existing law (1) to require all States to provide such a program; (2) to require that it be Statewide in application; and (3) to provide Federal matching of its cost at the 75 percent level.

Under existing law, the emergency assistance program, which has been adopted in about 25 jurisdictions, is matched by the Federal Government at the 50 percent level. The regular emergency assistance program will continue to be optional, and its rate of Federal matching will remain at 50 percent.

The same feature of existing law as to the nature of the emergency and the mode of assistance in the regular emergency program would be applicable to the new migrant program: Assistance would be furnished for a period not in excess of 30 days in any 12-month period in cases in which a child is without available resources; the payments, care, or services involved are necessary to avoid destitution of the child or to provide living arrangements for the child; and the destitution or need for living arrangements did not arise because the child or relative refused without good cause to accept employment or training for employment. Assistance could be in the form of money payments, payments in kind, or other payments as the State agency may specify with respect to, or medical care or any other type of remedial care in behalf of, the child or other member of the household in which the child is living, and other services as may be specified by the Secretary.

Effective date July 1, 1971.

F. OBLIGATION OF A DESERTING FATHER

(Sec. 540 of the bill)

Families may receive Aid to Families with Dependent Children if the father is dead, incapacitated, unemployed, or absent from the home. Absence from the home constitutes by far the major reason for dependency among children. In 1969, three out of four families receiving AFDC were eligible because of the father's absence from the home.

One out of six families is on welfare because of the father's desertion. With about 9 million AFDC recipients, this means that about 1,500,000 mothers and children are receiving welfare today because the father of the family has deserted.

An illustration of the impact of desertion on a city's AFDC rolls is included in the findings of a special review of AFDC in New York City by the Department of Health, Education, and Welfare and the New York State Department of Social Services.

According to this review, the number of AFDC women whose husbands had deserted them rose from 12,138 cases in 1961 to 52,855 cases in 1967, a 335.4 percent increase, as compared with a total caseload increase of 159.7 percent between 1961 and 1967. The number of cases of deserted wives and wives separated without court decree was 15,457 in 1961; 63,185 in 1967; and 79,147 in 1968. Thus, between 1961 and 1968 the cases of deserted or informally separated wives grew by 412 percent, as compared with a total caseload increase of 234.7 percent.

Nationally, the largest single cause of dependency among children is illegitimacy. In 28 percent of the families receiving AFDC, the mother is not married to the father of the child.

The Congress has attempted to deal with this aspect of the dependency problem in the past. Present law requires that the State welfare agency undertake to establish the paternity of each child receiving welfare who was born out of wedlock, and to secure support for him; if the child has been deserted or abandoned by his parent, the welfare agency is required to secure support for the child from the deserting parent, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. The State welfare agency is further required to enter into cooperative arrangements with the courts and with law enforcement officials to carry out this program. Access is authorized to both Social Security and Internal Revenue Service records in locating deserting parents.

These measures, however, have failed to stem the explosive growth of the welfare rolls in the past 3 years, a growth largely consisting of families in which there either never was a father or in which the father has deserted the family or is otherwise separated from the mother.

Officials from Milwaukee, Wis., in testimony before the committee urged that it be made a Federal offense for a father to leave a State to abandon his family.

During the hearing on the welfare bill, Secretary Richardson was asked his opinion about direct Federal action in desertion cases. He replied:

We would support legislation which made it a Federal crime to cross State lines for the purpose of evading parental responsibility. The only real problems that arise here—and I cannot speak to these—involve the responsibility that would thereby be put on the Justice Department and U.S. attorney's offices.

Generally speaking, Federal law enforcement officials, I think, have felt that this ought to be a State responsibility. This system is, in effect, an interstate compact designed to enable the States to work together and to trace and get money payments from fathers. From the standpoint of our Department to make this a Federal crime would help to reduce the problem, we think, and to that extent we would be for it. (P. 690 of hearings.)

The committee considers the provisions of present law useful and feels they should be retained. However, it is clear that further action is necessary to permit more extensive involvement of the Federal Government in cases where the father is able to avoid his parental responsibilities by crossing State lines.

First, the committee bill would make it a Federal misdemeanor for a father to cross State lines in order to avoid his family responsibilities. The penalty under this new amendment would be imprisonment for up to one year.

Second, the committee bill would provide that an individual who has deserted or abandoned his spouse, child, or children shall owe a monetary obligation to the United States equal to the Federal share of any welfare payments made to the spouse or child during the period of desertion or abandonment. In those cases where a court has issued an order for the support and maintenance of the deserted spouse or children, the obligations of the deserting parent would be limited to the amount specified by the court order.

Present law requires the State to seek to obtain a court order requiring the deserting parent to support his family. The committee feels it is desirable to continue to provide an incentive for the States to do this. Therefore, under the committee bill, if the State has obtained a court order, the Federal Government would attempt to recover both the Federal and non-Federal share of welfare payments to the deserting father's family. If the State has not obtained a court order, the Federal Government would only attempt to recover the Federal share of the welfare payments. The deserting parent's obligation could be collected in the same manner as any other obligation against the United States.

The bill also provides that information regarding the whereabouts of the deserting individual would be furnished, on request, by the Federal Government to the deserted spouse, or to the guardian or custodian of the child or children deserted, or their counsel, where a judgment for support has been obtained.

In an article entitled "The Crises in Welfare" written two years ago Daniel P. Moynihan stated:

While minority group spokesmen are increasingly protesting the oppressive features of the welfare system and liberal scholars are actively developing the concept of the constitutional rights of welfare recipients with respect to such matters as man in the house searches, it is nonetheless the fact that the poor of the United States today enjoy a quite unprecedented de facto freedom to abandon their children in the certain knowledge that society will care for them, and what is more, in a State such as New York, to care for them by quite decent standards. Through most of history a man who deserted his family pretty much assured that they would starve or near to it if he was not brought back, and that he would be horsewhipped if he were. Much attention is paid the fact that the number of able-bodied men receiving benefits under the AFDC program is so small. In February 1966, Robert H. Mugge of the Bureau of Family Services of HEW reported that of the 1,081,000 AFDC parents there were about 56,000 unemployed, but employable fathers. But in addition to the 110,000 incapacitated fathers, there were some 900,000 mothers of whom by far the greatest number had been divorced or deserted by their presumably able-bodied husbands.

Now, a working-class or middle-class American who chooses to leave his family is normally required first to go through elaborate legal proceedings and thereafter to devote much of his income to supporting them. Normally speaking, society gives him nothing. The fathers of AFDC families, however, simply disappear. Only a person invincibly prejudiced on behalf of the poor would deny that there are attractions in such freedom of movement.

It is the committee's hope that the measures contained in the committee bill will equate the responsibilities of a father of AFDC children with those of the father of a working-class or middle-class family.

Effective date—Immediate.

G. THE SUPREME COURT AND WELFARE CASES

Court decisions have played a major role in the phenomenal growth of the welfare rolls in the last three years. One of the most important of these cases—the so-called “man-in-the-house” decision—is based solely on a statutory interpretation. Other cases, such as the decision prohibiting the duration of residence requirements, are based on statutory interpretation with Constitutional implications. Still other cases apparently are predicated on the judicial finding that welfare is a property “right” rather than the traditional view that it is a “gratuity” granted as a privilege by the Congress and subject to such eligibility conditions as it decides to impose.

It should be remembered that welfare is a statutory right, and like any other statutory right, is subject to the establishment by Congress of specific conditions and limitations which may be altered or repealed by subsequent congressional action. In fact, the Social Security Act, in section 1104 makes explicit what would be the case in any event, that “the right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.” Under Secretary Veneman testified before the committee (p. 216 of the hearings), and Secretary Richardson agreed (p. 469 of the hearings) that there is no Constitutional right for a person to draw welfare. The following colloquy took place between Senator Long and Under Secretary Veneman at the hearings:

The CHAIRMAN. Do you believe that there is any constitutional right for a person to draw welfare money?

Mr. VENEMAN. No, sir.

The CHAIRMAN. I do not, either. I am glad we agree on that point.

Mr. VENEMAN. There is a statutory provision, sir, that allows certain people to draw welfare payments.

The “right to welfare” implies no vested, inherent or inalienable right to benefits. It confers no constitutionally protected benefit on the recipient. To the contrary, the right to welfare is no more substantial, and has no more legal effect, than any other benefit conferred by a generous legislature. The welfare system as we know it today has its legal genesis in the Social Security Act and the statutory rights granted under, and pursuant to, that Act can be extended, restricted, or otherwise altered or amended—or even repealed—by a subsequent act of Congress (or of a State legislature). It is this ability to change the nature of a statutory right which distinguishes it from a property right or any right considered inviolate under the Constitution. The committee firmly restates this view of the nature of the “right” to a welfare benefit.

DENIAL OF ELIGIBILITY FOR AID TO FAMILIES WITH DEPENDENT CHILDREN WHERE THERE IS A CONTINUING PARENT-CHILD RELATIONSHIP

(Sec. 541 of the bill)

Under present law, Aid to Families with Dependent Children is available to children who have been deprived of parental support by reason of the “continued absence from the home” of a parent. The

so-called "man-in-the-house" or "substitute father" statutes of the States were attempts to define the term "parent" under the Aid to Families With Dependent Children program for eligibility purposes. The State statutes have been varied, some emphasizing cohabitation with the mother as being determinative of the parental relation, while others have required indications of a positive relationship of the man with the child.

On June 17, 1968, the Supreme Court ruled that a State could not consider a child ineligible for Aid to Families with Dependent Children when there was a substitute father with no legal obligation to support the child. The Court decision was based on its interpretation of Congressional intent as expressed in the Social Security Act and its legislative history. The decision states: "We believe Congress intended the term 'parent' in section 406(a) of the Act * * * to include only those persons with a legal duty of support."

The implication of this decision, as made clear by subsequent cases, was that a State could not deny Aid to Families with Dependent Children even in the situation where there was a stepfather with substantial income. The committee believes that a legal obligation to support is too narrow a base upon which to determine eligibility and income accountability for a welfare program for families. The committee believes that the determination of whether a man is a "parent" within the meaning of this term in section 406 of the Social Security Act should depend on the total evaluation of his relationship with the child, with the following being positive indications of the existence of such a parental relationship:

- (1) The individual and the child are frequently seen together in public;
- (2) The individual is the parent of a half-brother or half-sister of the child;
- (3) The individual exercises parental control over the child;
- (4) The individual makes substantial gifts to the child or to members of his family;
- (5) The individual claims the child as a dependent for income tax purposes;
- (6) The individual arranges for the care of the child when his mother is ill or absent from the home;
- (7) The individual assumes responsibility for the child when there occurs in the child's life a crisis such as illness or detention by public authorities;
- (8) The individual is listed as the parent or guardian of the child in school records which are designed to indicate the identity of the parents or guardians of children;
- (9) The individual makes frequent visits to the place of residence of the child; and
- (10) The individual gives or uses as his address the address of such place of residence in dealing with his employer, his creditors, postal authorities, other public authorities, or others with whom he may have dealings, relationships, or obligations.

The committee amendment specifically states that: "Such a relationship between an adult individual and a child may be determined to exist in any case only after an evaluation of the [above] factors * * *

as well as any evidence which may refute any inference supported by evidence related to such factors." (Emphasis added.)

It should be further pointed out that the use of this provision would be optional with the States. If a State does affirmatively exercise its option, however, it must comply with this statutory method in determining the child-father relationship. The committee believes that this will provide coherent and uniform standards governing this delicate area of the law and provide a clear statement of statutory intent.

Effective date—January 1, 1971.

DURATION OF RESIDENCE REQUIREMENT

(Sec. 542 of the bill)

Under present Federal law the Secretary of Health, Education, and Welfare is required to approve all State plans for Aid to Families with Dependent Children which meet the requirements specified in section 402(a) unless the plan includes a duration of residence requirement denying aid to children who have resided in the State for one year preceding the date of application for aid (or to children born during that year and living with a parent or relative who has resided there for a year). In the programs of cash assistance for the aged, blind, and disabled, present law would permit, in addition to the requirement of one year's residence preceding the date of application, a requirement that the individual have resided in the State for five of the preceding nine years.

In April of last year, the Supreme Court ruled that the duration of residence requirement of the Connecticut and Pennsylvania AFDC programs constituted an action by those States which violated the equal protection clause of the 14th Amendment. The Supreme Court stated that the Federal statute "does not approve, much less prescribe, a one-year requirement" and went on to say that even if it were to assume "that Congress did approve the imposition of a one-year waiting period, it is the responsive *State* legislation which infringes constitutional rights." The court further declared that if somehow the constitutionality of the Federal law is involved that "insofar as it permits the one-year waiting-period requirement" it would be unconstitutional because "Congress may not authorize the States to violate the Equal Protection Clause."

This Supreme Court action in outlawing duration of residence requirements could have the effect of influencing States against any liberalization of their welfare programs for fear of attracting large numbers of needy persons from nearby States with less liberal programs. A dissenting member of the Supreme Court noted that "of longer-range importance, the field of welfare assistance is one in which there is a widely recognized need for fresh solutions and consequently for experimentation. Invalidation of welfare residence requirements might have the unfortunate consequence of discouraging the Federal and State Governments from establishing unusually generous welfare programs in particular areas on an experimental basis, because of fears that the program would cause an influx of persons seeking higher welfare payments." This Justice concluded that it was "particularly unfortunate that this judicial roadblock to the powers of

Congress in this field should occur at the very threshold of the current discussions regarding the 'federalizing' of these aspects of welfare relief."

The committee's amendment eliminates the constitutional question raised by the Supreme Court by making it an affirmative requirement of Federal law that State plans for cash public assistance under the Social Security Act include a requirement of one year's residence in the State as a condition of eligibility. (The committee's amendments would, however, not deny Federal matching to States which by virtue of State law do not in fact impose a duration of residency requirement.) Thus under the amendment, one year's duration of residence in a State would, in effect, be a nationally uniform condition of eligibility for assistance imposed by Federal law. Accordingly, the question of State violation of the equal protection clause of the 14th Amendment would be eliminated.

The committee recognizes that the one-year duration of residence requirement can impose a severe hardship on some families and could, in fact, discourage them from moving to a new State for even such admirable motives as seeking better employment opportunities. Accordingly, the committee added to that requirement a further requirement that the State which a recipient leaves must continue assistance payments to him, as long as he continues to be eligible for assistance, for a period of one year unless the new State of residence assumes this responsibility before the end of that 12-month period.

Taken together, the committee amendments to establish a residence requirement and to require the State of origin to continue payments for a year after the recipient moves, represent a significant improvement in the Federal-State welfare programs from the point of view of both the States and individuals involved. States which have found duration of residence requirements useful will be able to reinstitute them and be able to make improvements in their welfare programs without fear of creating substantial incentives to in-migration. Welfare recipients would, on the whole, be neither advantaged nor disadvantaged by the combined provisions. At least on a short-term basis, the level of welfare assistance provided in a given State would be made a neutral factor in the recipient's decision of whether to move there. In fact, it appears quite probable that the overall effect of the committee's amendments would be to facilitate the interstate movement of welfare recipients to seek employment or for other motives. A recipient contemplating such a move would generally know what he could expect in the way of assistance for the first year and would not face the prospect of a period with no assistance whatever while he was trying to establish his eligibility under the program of the new State.

Effective date—July 1, 1971.

LIMITATION ON DURATION OF APPEALS PROCESS

(Sec. 543 of the bill)

The committee's bill requires State welfare agencies to reach a final decision on the appeal of a welfare recipient within 30 days following the day the recipient was notified of the agency's intention to reduce or terminate assistance. The bill also requires the repayment to the

agency of amounts which a recipient receives during the period of the appeal if it is determined that he was not entitled to them. Any amounts not repaid are to be considered an obligation of the recipient to be withheld from any future assistance payments to which the individual may be entitled.

The committee's action is designed to assure that the appeals procedure will be handled expeditiously by the States, and also to assure that appeals will not be made frivolously. It is the view of the committee that these amendments to existing law are necessary in view of the recent Supreme Court decision that assistance payments cannot be terminated before a recipient is afforded an evidentiary hearing.

Effective date—July 1, 1971.

STATE PERMITTED TO SEEK TO ESTABLISH NAME OF PUTATIVE FATHER

(Sec. 544 of the bill)

Of all families receiving Aid to Families with Dependent Children, those in which the father is not married to the mother constitute the single largest category (28 percent of all families). It is also the category that has been showing the most rapid growth. The Congress has clearly established in legislation its belief in the importance of making every reasonable effort to establish the paternity of a child born out of wedlock, both for the sake of the child and the family, and as a matter of good social policy. It is for this reason that a provision was written into the Social Security Act (sec. 402(a)(17)(A)) requiring the State welfare agency "in the case of a child born out of wedlock who is receiving aid to families with dependent children, to establish the paternity of such child. . . ."

Despite this clear legislative history, a U.S. District Court in August 1969 ruled that a mother's refusal to name the father of her illegitimate child could not result in denial of Aid to Families with Dependent Children. The applicable State regulation was held to be inconsistent with the provision in Federal law that AFDC be "promptly furnished to all eligible individuals" on the grounds that the State regulation imposed an additional condition of eligibility not required by Federal law.

The dissenting opinion in the case clearly sets forth the Congressional intent:

The focal statutory provision which has application here is § 602(a)(7) [Sec. 402(a)(7) of the Social Security Act]; it reads in part:

(A State plan for aid and services to needy families with children must) . . . provide that the State agency shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming

such aid, as well as any expenses reasonably attributable to the earning of any such income.

It is fundamental in this statutory scheme, that the sources of all family income be disclosed as a prerequisite to an applicant's qualifying for eligibility benefits. Thus the mother's disclosure of the known identity of a legally liable putative father is certainly an essential element in correctly evaluating the applicant-mother's support capabilities, as stated on the application in behalf of herself and her dependent children. Her limited disclosure of actual current income is incomplete, if any of the available sources remain unrevealed.

She is the actual party plaintiff in this action; it is to her that the government welfare benefits are directly paid. It is through her, that the family unit is sought to be preserved, as an essential unit of our society. She is the actual recipient of these moneys as head of the household. It is the plan and expectation, that her maternal interest as natural parent and guardian will assure to the dependent child the full benefits of the government allotment.

Unless the principle of personal parental responsibility is to be abandoned, as an obsolete cornerstone for gaging welfare eligibility, a full disclosure is a necessary and implied governmental prerogative, which requires the applicant to disclose all relevant information. Absent this personal responsibility and cooperativeness between the applicant-mother and the government, the effectiveness of the program would be seriously challenged because she is the sole source of this information; and without it the system designed to establish paternity could not function. . . .

Congress created this system which requires only the identity of the father, to allow enforcement officials with the assistance of the Internal Revenue Service and the social security files, to locate an absconding father. It is one of the very few occasions when the information in those records is statutorily made available for use outside the agencies' official business. Could it be that Congress contemplated this elaborate system would be paralyzed by an uncooperative applicant-mother who could still successfully insist that she be paid her full monetary allotment?

Clearly, the answer is no. Under the committee bill, the intent of the Congress that States must attempt to establish the paternity of a child born out of wedlock is reaffirmed by providing that the requirement that welfare be furnished "promptly" may not preclude a State from seeking the aid of a mother in identifying the father of the child.

Effective date—Immediate.

HOME VISITS AS A CONDITION OF WELFARE

(Sec. 545 of the bill)

The committee bill permits the States, at their option, to require as a condition of welfare eligibility that recipients allow a caseworker

to visit the home. In doing so, the committee is not endorsing the so-called "midnight raids," which have been generally considered objectionable as a means of enforcing welfare eligibility rules. The bill specifically requires that such home visits must be made at a reasonable time and with reasonable advance notice.

However, the committee wants to make clear its belief that in "means test" programs, such as those under the public assistance titles of the Social Security Act, States should have the right to take reasonable steps to establish the facts relating to eligibility. If a State decides that visits by caseworkers to the homes of certain recipients are essential to the establishment of necessary facts, then it should be allowed to provide for these through its laws or regulations. The committee recognizes that there may well be circumstances under which the interests of the welfare recipient and of the Government may best be served by visits of the caseworker to the home.

Effective date—January 1, 1971.

H. USE OF FEDERAL FUNDS TO UNDERMINE FEDERAL PROGRAMS

(Sec. 546 of the bill)

One of the often-stated aims of the Legal Services program of the Office of Economic Opportunity is:

The use of the judicial system and the administrative process to effect changes in laws and institutions which unfairly and adversely affect the poor. (Page 534 of the Narrative Justifications presented by OEO at the Senate fiscal year 1971 Appropriations Hearing on July 20, 1970.)

In carrying out this broad, highly subjective, and basically legislative function, the committee notes that certain Legal Services activities have been aimed directly at undermining the welfare programs—which are, of course, established by duly enacted Federal laws and properly prescribed Federal regulations.

For example, a document entitled "Know Your Welfare Rights" prepared by the Tulare County Legal Service Association (paid from Federal poverty funds) stated: "If you don't want to work there is no reason why welfare can force you to work, no matter what your welfare worker says." The pamphlet was subsequently withdrawn from circulation.

Recently the Center of Social Welfare Policy and Law at Columbia University, funded by the Office of Economic Opportunity, published a book entitled "How to Commence Welfare Litigation in a Federal Court, Including Model Annotated Papers." This publication is explicitly designed to assist legal services attorneys who wish to commence welfare litigation in a Federal district court.

In response to a question by the Chairman of the committee when the Office of Economic Opportunity appeared before the committee during the hearings on the welfare bill, information was provided stating that one or more OEO legal services projects were involved in each of the major cases affecting welfare law in recent years. These decisions involved the prohibition of duration of residence requirements, voiding the man-in-the-house rules, requiring a hearing before assistance can be terminated, prohibiting denial of welfare

for refusal to allow a case-worker in the home, and prohibiting denial of welfare for refusal to name the putative father (the reply appears in pt. 2 of hearings, pp. 969-970).

The success of the program's aims was asserted in OEO's Narrative Justification at the House Appropriations hearings for the fiscal year 1970:

Several landmark decisions were won by Legal Services attorneys during FY 1969. Of major importance was a U.S. Supreme Court decision ruling that residency requirements for the receipt of welfare benefits were unconstitutional. Also, the court ruled that the welfare "substitute father" regulation was illegal. . . .

The committee is unwilling to accept the implication of these activities: that the Legal Services lawyers are better qualified than the Congress to, in effect, determine national policy regarding the poor. The committee draws a distinction between legal representation that involves assisting poor individuals with day-to-day problems in such areas as support payments, landlord-tenant relations, consumer issues, or even arbitrary actions of local welfare departments—and the type of advocacy that aims at undermining established institutions that were consciously created through acts of Congress. If the welfare statutes are inadequate, and there is little disagreement on this point, then the proper forum for improving them is the legislative branch of our Government, not the judicial.

Accordingly, the committee's amendment would prohibit the use of Federal funds to pay, directly or indirectly, the compensation or expenses of any individual who in any way participates in action relating to litigation which is designed to nullify Congressional statutes or policy under the Social Security Act.

Effective date—Immediate.

I. REGULATIONS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The committee is concerned at the extent to which the Department of Health, Education, and Welfare has imposed requirements on the States which go far beyond the statute itself and in some cases bear no relationship to the law.

Section 1102 of the Social Security Act authorizes the Secretary of Health, Education, and Welfare to "make and publish such rules and regulations, not inconsistent with this Act, *as may be necessary to the efficient administration* of the functions" he is charged with under the Act. (Emphasis added.) Under this broad authority, the Secretary has attempted through regulation to make substantial legislative changes in the welfare provisions of the Social Security Act.

Governor Warren E. Hearnes of Missouri, testifying on behalf of the National Governors' Conference, told the committee in hearings:

. . . We have had a great deal of problems fiscally with laws passed by the Congress in the welfare field, but we have many, many times over problems created by regulations from HEW

. . . It is almost every session that we are required to enact new laws to conform with their regulations.

... These things are very exasperating for the Governors and the legislatures to try to stay not only within the intent of Congress but with what Congress has evidently done and given to HEW so much power to promulgate regulations. (pp. 1974, 2061 of hearings on the Family Assistance Plan)

The Congress did not intend that the regulatory authority in section 1102 be employed by the Department of Health, Education, and Welfare as a substitute for an act of Congress. Several provisions of the committee bill will make clear the Congressional intention to curb the use of this authority in regulatory lawmaking.

"DECLARATION METHOD" OF DETERMINING ELIGIBILITY

(Sec. 550 of the bill)

Generally speaking, the usual method of determining eligibility for public assistance has involved the verification of information provided by the applicant for assistance through a visit to the applicant's home and from other sources. For persons found eligible for assistance, re-determination of eligibility is required at least annually (six months in the case of Aid to Families with Dependent Children), and similar procedures are followed.

Regulations issued by the Department of Health, Education, and Welfare on January 17, 1969, required States to test a simplified method for the determination of eligibility for welfare in selected areas of the State. The simplified or "declaration method" provides for eligibility determinations to be based to the maximum extent possible on the information furnished by the applicant, without routine interviewing of the applicant and without routine verification and investigation by the case worker. The regulations requiring testing of the declaration method arbitrarily stated that a three percent level of ineligibility would be considered "acceptable."

In May of this year, Secretary Finch announced that the results of the testing were so conclusive that he was requiring the States, through regulation, to use the simplified declaration method in welfare programs for the aged, blind, and disabled beginning July 1, 1970.

The committee asked the General Accounting Office to look into the testing of the method to see if the results were truly conclusive. In its report, the General Accounting Office found that:

1. The simplified declaration method required by the new Health, Education, and Welfare regulations in fact was pre-tested almost nowhere; most States actually used oral interviewing or other forms of verification of the information supplied by the applicant;

2. Five-sixths of the total cases tested were simply redeterminations of the eligibility of persons who had previously been subjected to the usual (nondeclaration) application procedures, and thus might not be indicative of the manner in which the simplified method will operate; and

3. The sample size under the testing was so small that there is a substantial probability that the ineligibility level exceeded Health, Education, and Welfare's arbitrary 3-percent "acceptable" level.

In view of the inconsistency of the test findings, the committee feels that use of the declaration method should remain optional with the States rather than mandatory. The committee bill accordingly specifies that the Secretary may not require use of the declaration method by regulation.

Effective date—Immediate.

DEFINITION OF UNEMPLOYMENT

(Sec. 551 of the bill)

Under present law Aid to Families with Dependent Children may be provided to needy families in which the children are dependent because of the death, incapacity, or absence of a parent—and, at the State's option, if the father is unemployed. Twenty-three States currently provide assistance to needy families in which the father is unemployed. Before the Social Security Amendments of 1967, each State used its own definition of "unemployment." The committee felt that a uniform national definition was desirable, and authorized the Secretary of Health, Education, and Welfare to define unemployment. Unfortunately, the Department of Health, Education, and Welfare issued regulations defining unemployment which go far beyond anything contemplated by the committee in 1967. Under the regulations, unemployment is defined in a way that requires States with unemployed father programs under AFDC to include "any father who is employed less than 30 hours a week" and the State may include "any father who is employed less than 35 hours a week."

During hearings on the Family Assistance Plan, Secretary Richardson agreed that an individual working regularly 34 hours a week could not be considered "unemployed." At that time he stated his intention to change the definition:

Senator TALMADGE. Mr. Secretary, reverting to another matter, in our previous hearings on this bill, several members of the committee noted that regulations of the Department permitted States to consider an individual working less than 35 hours as being unemployed. Secretary Finch agreed that he had difficulty conceiving of a man working regularly at 34 hours a week as being unemployed. Yet, to the best of my knowledge, there has been no change in this regulation.

If I read correctly, the electrical workers in New York City recently negotiated contracts for a 20-hour week. Why should not the system have a more realistic definition of unemployment?

Secretary RICHARDSON. We should have a more realistic definition, Senator. I would again emphasize that if our recommendations are all adopted, that problem will disappear with the declining rolls of the unemployed father category.

Senator TALMADGE. Is it not a problem now that ought to be corrected by regulation now, rather than waiting on Congress?

Secretary RICHARDSON. I think it should, and I shall follow that up.

To date, the regulations of the Department of Health, Education, and Welfare have not been changed. Accordingly, the committee bill includes an amendment defining a father as unemployed for purposes of AFDC eligibility if he has worked less than 10 hours in the last week or less than 80 hours in the last 30 days.

Effective date—July 1, 1971.

VETO OF WIN CHILD CARE SERVICES

(Sec. 520(a) (7) of the bill)

Department of Health, Education, and Welfare regulations state that "child care services, including in-home and out-of-home services, must be available or provided to all persons referred to and enrolled in the work incentive program and to other persons for whom the agency has required training or employment. Such care must be suitable for the individual child, and the parents must be involved and agree to the type of care to be provided."

This apparent absolute veto power over child care by the mother is not in accord with Congressional intent. The committee bill provides that if child care services are necessary to permit participation of a mother in the Work Incentive Program, she should be given a choice of type of child care if more than one type is available, but she may not avoid participation in work and training by refusal to accept child care.

Effective date—Immediate.

ADVISORY COMMITTEES ON WELFARE

(Sec. 552 of the bill)

Regulations issued by the Department of Health, Education, and Welfare require States to establish a welfare advisory committee for AFDC and child welfare programs "at the State level and at local levels where the programs are locally administered," with the cost of the advisory committees and their staffs borne by the States (with Federal matching) as part of the cost of administering the welfare programs.

The committee has no objection to the establishment of such advisory committees where the State wishes to do so, but finds that there is no statutory basis for requiring their establishment. Accordingly, the committee bill would make the setting up of welfare advisory committees and the nature of such committees a matter of State discretion.

Effective date—Immediate.

J. USE OF SOCIAL SECURITY NUMBERS

(Sec. 560 of the bill)

The committee bill requires applicants for public assistance to furnish their social security numbers to State welfare agencies. These agencies, in turn, are required by the bill to use recipients' social security numbers in the administration of assistance programs.

For example, it is expected that States would use social security numbers for case file identification, for cross-checking purposes, and

as an aid in the compilation of statistical data. The committee feels that this provision is a logical extension of the use of social security numbers for identification purposes—a procedure already in widespread use by governmental agencies and others. In fact, the committee understands that a number of States have, on their own initiative, undertaken to use social security numbers in administering their welfare programs. The committee believes that this practice should be made a nationally uniform requirement of Federal law with a view to improving the administration of welfare programs, aiding in the detection and prevention of fraudulent practices and facilitating the collection and analysis of welfare statistics on both the State and National levels.

Effective date—January 1, 1972.

K. TESTING OF ALTERNATIVES TO AFDC

(Secs. 561 and 562 of the bill)

Over the years, the Congress has enacted a wide range of social welfare programs designed to assure that all Americans, including the needy and the unfortunate, will have the opportunity to obtain at least the basic necessities for a life of decency and dignity. Some of these programs have proven successful. Too often, however, such programs have been enacted on the basis of estimates which later proved to be far too low with respect to costs and far too high with respect to effectiveness.

The committee feels that, in the light of this sad experience, this is not the time to adopt a major new welfare program which has the potential of costing the American taxpayer vast sums of money until such a program and alternative approaches have been thoroughly examined on an experimental basis. Accordingly, while the committee agrees with the generally accepted sentiment that the problems of the present program of aid to families with dependent children are reaching overwhelming proportions, it cannot agree that the present system is so bad that any untested alternative would be preferable merely because it is new or different. The committee bill takes the more responsible approach of adopting a number of changes in the present welfare system designed to correct its worst and most obvious defects, while at the same time providing for the testing of possible alternatives to the present system.

The committee bill provides for the Secretary of Health, Education, and Welfare to conduct up to four tests of possible alternatives to the AFDC program. One or two of these tests would test a "family assistance" type proposal for welfare, and one or two of the tests would test a "workfare" type proposal. In addition, the bill provides for a test in which a program of rehabilitation of welfare recipients would be administered by vocational rehabilitation personnel.

The committee expects that these tests will provide a sound basis for rational legislative action in the welfare area.

It is hoped that each test will produce data from which there can be estimated for the various types of programs the cost, extent of participation, and effectiveness in reducing dependency on welfare which could be expected if such programs were adopted as a substitute for AFDC. These tests should also provide valuable administra-

tive experience which would facilitate the implementation of any of the tested proposals which might eventually be enacted.

GENERAL REQUIREMENTS APPLICABLE TO TESTS OF AFDC ALTERNATIVES

In drawing up its proposals for the testing of alternatives to the present welfare system, the committee has profited from the experience of the relatively small-scale income maintenance experiment being conducted with OEO funds in the States of New Jersey and Pennsylvania. A General Accounting Office evaluation of that project requested by the committee revealed a number of pitfalls which the committee bill is designed to avoid. For example, the GAO report found that an attempt was made to draw conclusions from the New Jersey experiment before it had run long enough to provide a reliable data base to support such conclusions. The committee bill requires, therefore, that all tests be conducted for a minimum of two years unless Congress authorized earlier termination. It is anticipated that such authorization would be requested and granted only if it became obvious that a test in progress was a total failure and would yield no useful results. Other problems tending to lessen the value of the OEO experiment were the limited size of the sample population and the availability to those in the experiment of alternative benefits under existing welfare programs. These difficulties are avoided by provisions of the committee bill which require that all eligible families in the test area be permitted to participate in it and that no families in that area may, during the period of the test, receive aid or assistance under AFDC.

The committee feels that the Department of Health, Education, and Welfare should have considerable flexibility in choosing the areas in which these tests are to be conducted. Accordingly, the bill permits a given test to be conducted either throughout an entire State or only within certain areas of a State. The committee wants to make clear, however, its intention that the areas which the Department does choose for each test should be broadly representative of the country as a whole so that the data from the tests may serve as a reliable basis for future Congressional action.

The committee also desires to assure that the tests will be conducted in such a way that valid comparisons among the various alternatives can be made. The bill, therefore, requires that the Department conduct the same number of "workfare" tests as "family assistance" tests—either one or two of each. In each pair of tests (one "workfare" and one "family assistance") the beginning and ending dates of the two tests must be the same, the number of participants must be approximately the same, and the areas in which the two tests are conducted must be comparable as to population, per capita income, unemployment level, and other relevant factors.

The committee bill also provides that the tests are to be conducted with State cooperation and with State sharing in the costs of the tests. The State share of costs, however, could not exceed its share of the costs under AFDC (as determined by its costs for the test area in the 12 months before the test begins).

To assure that the tests are so designed as to fulfill their objective of providing Congress with the necessary data on which to base further welfare legislation, the bill requires the Secretary of Health, Education, and Welfare to give a complete and detailed description of the test plans before they are implemented to this committee and to the Committee on Ways and Means of the House of Representatives. The Secretary would also be required to give consideration to any comments and suggestions of the committees and to report to Congress at least annually on the operations of the test programs.

In addition, the Secretary would be required in planning the tests and in preparing reports on the tests to consult with the General Accounting Office which also would have full access to the books and records concerning the tests and would itself annually or more often conduct audits of the test programs and make reports to Congress concerning them. At the conclusion of the tests, complete reports with recommendations would be submitted to Congress by both the Secretary of Health, Education, and Welfare and the Comptroller General.

TESTS OF "FAMILY ASSISTANCE" PROGRAMS

The committee bill provides for the Department of Health, Education, and Welfare to conduct one or two tests of "family assistance" programs. Essentially, "family assistance" programs would be similar to the present welfare program of Aid to Families with Dependent Children except that eligibility would not be restricted to families in which children are deprived of parental support because of the death, incapacity, or absence from the home of a parent or because of the father's unemployment. In addition to such AFDC-type families, a "family assistance" program would also cover low income families in which both parents are present and nondisabled and in which the father is working full time, but is not earning a sufficient amount to meet the family's needs as determined by an income standard related to family size.

The "family assistance" tests would provide money payments to families with incomes below certain minimum levels. Non-disabled adults (with certain exceptions) could not refuse to accept employment or training; and placement, employment training, and supportive services would be provided. In determining eligibility and the amount of assistance, a portion of earnings would be disregarded in order to provide a monetary incentive for work.

TESTS OF "WORKFARE" PROGRAMS

The committee bill provides for one or two "workfare" tests to be conducted at the same time as the "family assistance" tests. A "workfare" program, under the provisions of the bill, would in large part cover the same persons eligible for "family assistance"—but while the "family assistance" tests would follow the traditional welfare approach, this proposal would stress "workfare" as a basis of entitlement for those able to work. A sharp distinction would be made between welfare and "workfare." In effect, a presumption would be made that certain groups (the aged, blind, disabled, and families with preschool age children where the father is dead, absent, or dis-

abled) are not employable. These persons would be eligible for cash welfare payments amounting to a guaranteed minimum income. For all other groups, however, there would be no guaranteed minimum income but only a guaranteed work opportunity, with training and other preparation for employment where necessary.

Thus, the "workfare" proposal would restrict the types of families eligible to receive welfare, and other families with incomes below the specified standards would be expected to participate in the "workfare" program. Participants in the "workfare" program would have their wages supplemented if they are below the minimum wage. Allowances would also be paid to those in training. The policy incorporated in the "workfare" test proposals is that it should always be more profitable for a mother with no children of preschool age heading a family to work than to remain at home and receive welfare payments; and mothers who head families with children of preschool age should be given a choice. In order for this policy to be carried out, large-scale day care and job development programs must be initiated, and the "workfare" test provisions of the bill provide for such programs, including programs of subsidized public service employment.

One possible way in which the "workfare" test provisions could be carried out would be through an employment corporation created to administer the proposal. It would be the corporation's job to secure employment in the community at least at the minimum wage for persons registering for the workfare program. If jobs could not be found at the minimum wage, the registrant could become an employee of the corporation, which would contract out for his services on a temporary or regular basis. If the corporation charged the employer less than the minimum wage, the employee could receive a wage perhaps half-way between the charge to the employer and the minimum wage. For example, if the employer paid \$1.00 per hour, the Corporation could pay the employee \$1.30 per hour (half way between \$1.00 and \$1.60). If after evaluating an employee's improved productivity the corporation decided to charge \$1.20 per hour for his services, the employee would receive \$1.40 per hour. Once his wages had reached the minimum wage, he would no longer be an employee of the corporation.

An employee of the corporation might be paid \$1.00 per hour while in full-time training, or if he is willing to work but there is no job available.

Whether through such a corporation or through some other method of wage subsidization, each "workfare" test proposal would consist of at least these elements:

- Welfare payments to those unable to work (the aged, blind, and disabled, and families with preschool age children where the father is dead, absent, or disabled);
- A workfare program of guaranteed work opportunities for families headed by a person able to work;
- Day care for children of low-income working mothers; and
- Other appropriate supportive services.

PILOT PROJECT TO TEST THE ADMINISTRATION OF WELFARE
PROGRAMS BY VOCATIONAL REHABILITATION PERSONNEL

In recent years, analogies have frequently been drawn between those who suffer from physical disabilities and those whose lack of cultural or educational background places them at a substantial disadvantage in competing for jobs in the labor market. The committee agrees that these analogies have a certain validity in that both groups are in a very real sense handicapped.

Further, the committee is impressed with the extent to which personnel engaged in the profession of fostering vocational rehabilitation have been able to motivate the physically disabled with the desire to overcome their handicaps and have been able through such motivation and through training to restore disabled individuals to useful, productive, and independent lives. Unfortunately, public assistance and manpower agencies have often not had similar success in rehabilitating welfare recipients. The committee is not sure that the welfare group will be as susceptible to rehabilitation techniques as the less socially deprived segments of the population which have generally constituted caseloads of vocational rehabilitation agencies. The committee bill, therefore, authorizes a pilot project designed to find out whether the methods and attitudes of those who have been successful in rehabilitating the physically disabled can be applied with equal success to welfare recipients.

Under the provisions of the bill, this project would be run concurrently with the first "family assistance" and "workfare" tests and in a comparable area. AFDC payments would be suspended in the area for the duration of the test, but equivalent benefits would be provided to those who would otherwise have been eligible for AFDC. In administering the project, the Secretary of Health, Education, and Welfare is directed to use the personnel and facilities of the Rehabilitation Services Administration. The objective of the project is to encourage and assist adult individuals with a potential for work to prepare for and obtain employment. Necessary counseling, rehabilitative, and other services would be provided together with appropriate job training.

The "workfare" and "family assistance" test provisions relating to reports to Congress and requiring consultation between the Department and the committees and the Department and the General Accounting Office are also applicable to this pilot project.

IX. VETERANS' PENSION INCREASES



Veterans' Pension Increases

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IX. VETERANS' PENSION INCREASES

(Sec. 607 of the bill)

NATURE OF PENSION BENEFITS

Since our Nation's independence was declared, some 40 million persons have served in its Armed Forces. After each major conflict in which the United States has been involved, benefits have been provided for veterans of the conflict. A major distinction is made between *service-connected benefits* for veterans who are disabled as a result of their military service or for the dependents of veterans who die as a result of service, and *non-service-connected benefits* which have been enacted not because of needs arising directly from military service, but on the ground that the Government owes a special obligation to those who were in military service during time of war but who are now in need.

Pensions are the major type of non-service-connected benefit. Non-service-connected pension benefits date back to the Revolutionary War, although they did not appear until 1818, 35 years after the Revolution ended. Such benefits have also been provided for veterans of every one of the major conflicts in which the United States has engaged. In the 19th century, pension laws were enacted many years after the conflict to which they pertained. Today, the same permanent pension laws apply to the veterans of World War I, World War II, the Korean conflict, and the Vietnam era. Under the current law, a veteran may be eligible for pension benefits if:

- He served in the Armed Forces at least 90 days, including at least one day of service during wartime;

- His income does not exceed limits specified in the law (currently \$2,000 if the veteran is single, \$3,200 if he has dependents);

- He is permanently and totally disabled (for purposes of the pension law all veterans 65 or older are defined as permanently and totally disabled); and

- His net worth does not exceed a limitation determined by the Veterans' Administration.

Widows and minor children of wartime veterans are also eligible for pension benefits if they are needy.

Before 1960, pensions for veterans of World War I, World War II, and the Korean Conflict were provided on the basis of a flat amount (generally \$78.75 per month) if the veteran's income did not exceed a specified figure—regardless whether his annual income was \$100 or \$1,000, and whether he was single or married. Legislation was enacted effective July 1, 1960, taking a first step in relating benefits more closely to need. Under the new law, married veterans were eligible for higher benefits than single veterans, and veterans with less income were eli-

gible for higher pensions than veterans with higher incomes. Veterans receiving benefits under the "old law" before 1960 were permitted to continue to do so if they wished to, but as pension benefits under the "new law" have been improved, many "old law" veterans have chosen to receive benefits under the current law.

CHARACTERISTICS OF PENSIONERS

There are presently about 1.9 million pensioners; five-sixths of them receive benefits under the current law, while one-sixth continue to receive benefits under the "old law" in effect before 1960.

Pensioners are primarily older persons; 7 out of 10 veterans receiving pensions served in World War I, and three out of four widows receiving pensions were married to veterans with World War I service. The period of service for pensioners under the current law is shown in table 1 below.

TABLE 1.—*Pensioners under current law by period of military service*

	Veterans	Widows
World War I.....	490, 253	474, 860
World War II.....	347, 566	217, 604
Korean conflict.....	24, 109	18, 271
Vietnam era.....	1, 320	1, 303
Total.....	863, 248	712, 038

A significant number of pensioners under the current law have virtually no other source of income other than their pension. The income of pensioners (other than their pensions) is shown in table 2 following:

TABLE 2.—*Pensioners under current law by income other than pensions*

Income range	Veteran alone		Veteran with dependents		Widow alone		Widow with children	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Less than \$100.....	74, 700	25	56, 600	10	94, 500	17	8, 700	6
\$100 to \$500.....	13, 900	5	12, 100	2	32, 900	6	14, 700	10
\$500 to \$1,000.....	94, 300	32	100, 800	18	207, 200	36	38, 700	28
\$1,000 to \$1,500.....	73, 100	25	152, 300	27	182, 500	32	37, 400	26
\$1,500 to \$2,000.....	37, 300	13	132, 600	23	53, 700	9	16, 600	12
\$2,000 to \$2,500.....	-----	-----	56, 600	10	-----	-----	11, 100	8
\$2,500 to \$3,200.....	-----	-----	58, 900	10	-----	-----	14, 000	10
Total.....	293, 300	100	569, 900	100	570, 800	100	141, 200	100

The income pensioners have in addition to their pensions comes from a variety of sources, but three out of four pensioners are social security beneficiaries.

TABLE 3.—*Veterans' pensions in fiscal year 1970*

	Average cases	Average cost	Cost
Pensions (total)-----	2, 249, 901	\$1, 007	\$2, 264, 546, 000
Veterans (total)-----	1, 105, 103	1, 228	1, 357, 113, 000
Indian wars-----	2	2, 000	4, 000
Spanish-American War-----	4, 830	1, 564	7, 554, 000
World War I-----	717, 772	1, 153	827, 316, 000
World War II-----	356, 339	1, 358	483, 978, 000
Korean conflict-----	24, 952	1, 448	36, 143, 000
Vietnam era-----	1, 108	1, 895	2, 100, 000
Peacetime service-----	100	180	18, 000
Survivors (total)-----	1, 144, 798	793	907, 433, 000
Indian wars-----	186	828	154, 000
Civil War-----	912	1, 022	932, 000
Spanish-American War-----	43, 661	889	38, 821, 000
World War I-----	590, 823	716	423, 188, 000
World War II-----	448, 821	858	385, 277, 000
Korean conflict-----	57, 917	982	56, 876, 000
Vietnam era-----	2, 462	886	2, 182, 000
Peacetime service-----	16	188	3, 000

VETERANS' PENSIONS AND SOCIAL SECURITY

As mentioned above, under current law pensions for veterans are related to need as measured primarily by income. Thus as social security benefits are increased, pension payments decrease. Since many pensioners are also social security beneficiaries, pressure builds up to insulate the pension from the effect of the social security increase.

Several approaches have been tried in the past to soften the impact of social security increases on veterans' pensions. In 1964, when a social security increase was pending in the Congress, a veterans' bill was passed allowing 10 percent of social security benefits (and other types of retirement income) to be disregarded in determining the amount of the pension payment. The remedy raised additional problems, however, for the 10 percent disregard created an inequitable distinction between those veterans who have income subject to the 10-percent exclusion and those who do not. A situation can arise in which two veterans with identical income (and thus identical need) receive different pension amounts.

In landmark legislation enacted in 1968, the pension program was thoroughly revised and improved. Pension benefits were much more closely related to need in order to end the previous situation under which a veteran could lose more in a pension reduction than he gained from a social security increase. In addition, the 1968 legislation pro-

vided for a disregard of the 1968 social security increase during 1968 and 1969. Unfortunately, this temporary disregard approach also proved to have defects.

Under present law, an increase in social security benefits is not taken into account for pension purposes until the calendar year after it goes into effect. Thus the social security benefit increase which became effective in 1970 will have no impact on veterans' pensions until January 1971.

If no legislation is enacted in 1970, the Veterans' Administration estimates that about 1,230,000 pensioners—69 percent of those on the rolls under current law—will face a pension loss beginning January 1971. Of course, a veteran receiving a pension in 1971 would find that his total income will still be higher than it was before the social security benefit increase, since the pension reduction is considerably less than the social security increase.

Under the proposed pension schedule in the committee bill, only 160,000 pensioners—9 percent of those on the rolls under current law—would face a pension loss. This 9 percent represents the pensioners who have received a relatively substantial increase in social security benefits this year; their reduction under the committee bill would of course be less than under present law.

More than a million pensioners would face pension reductions next January under present law but not under the committee bill.

Under the committee bill, the discriminatory exclusion of 10 percent of social security and certain other types of income would be eliminated, but the increased pension schedule in the committee bill is so devised that no veteran or widow would receive a lower benefit as a result of the elimination of the 10 percent exclusion. In fact, almost all pensioners would receive some increase.

INCOME LIMITATIONS

Under present law pension benefits are related to income, but no veteran or widow alone is eligible for a pension if his or her income exceeds \$2,000. The committee bill would increase the income limitation from \$2,000 to \$2,300.

The income limitation for veterans or widows with dependents would be increased from \$3,200 to \$3,600.

REVISED PENSION SCHEDULES

Pension benefits under present law and under the committee bill are shown in the following tables:

TABLE 4.—*Veteran alone*

Annual income		Monthly pension	
More than—	But equal to or less than—	Present law	Committee bill
-----	\$300	\$110	\$120
\$300	400	108	120
400	500	106	117
500	600	104	114
600	700	100	110
700	800	96	106
800	900	92	102
900	1, 000	88	98
1, 000	1, 100	84	94
1, 100	1, 200	79	90
1, 200	1, 300	75	86
1, 300	1, 400	69	81
1, 400	1, 500	63	76
1, 500	1, 600	57	70
1, 600	1, 700	51	64
1, 700	1, 800	45	58
1, 800	1, 900	37	52
1, 900	2, 000	29	46
2, 000	2, 100	-----	38
2, 100	2, 200	-----	34
2, 200	2, 300	-----	30

TABLE 5.—*Veteran with dependents*

Annual income		Monthly pension					
More than—	But equal to or less than—	Veteran with 1 dependent		Veteran with 2 dependents		Veteran with 3 or more dependents	
		Present law	Committee bill	Present law	Committee bill	Present law	Committee bill
	\$500	\$120	\$130	\$125	\$135	\$130	\$140
\$500	600	118	130	123	135	128	140
600	700	116	128	121	133	126	137
700	800	114	126	119	131	124	134
800	900	112	124	117	129	122	133
900	1,000	109	122	114	127	119	128
1,000	1,100	107	120	107	125	107	125
1,100	1,200	105	118	105	122	105	122
1,200	1,300	103	116	103	119	103	119
1,300	1,400	101	114	101	116	101	116
1,400	1,500	99	112	99	113	99	113
1,500	1,600	96	110	96	110	96	110
1,600	1,700	93	107	93	107	93	107
1,700	1,800	90	104	90	104	90	104
1,800	1,900	87	101	87	101	87	101
1,900	2,000	84	98	84	98	84	98
2,000	2,100	81	95	81	95	81	95
2,100	2,200	78	92	78	92	78	92
2,200	2,300	75	89	75	89	75	89
2,300	2,400	72	86	72	86	72	86
2,400	2,500	69	83	69	83	69	83
2,500	2,600	66	80	66	80	66	80
2,600	2,700	62	77	62	77	62	77
2,700	2,800	58	74	58	74	58	74
2,800	2,900	54	71	54	71	54	71
2,900	3,000	50	68	50	68	50	68
3,000	3,100	42	64	42	64	42	64
3,100	3,200	34	60	34	60	34	60
3,200	3,300	—	56	—	56	—	56
3,300	3,400	—	51	—	51	—	51
3,400	3,500	—	43	—	43	—	43
3,500	3,600	—	35	—	35	—	35

TABLE 6.—*Widow alone*

Annual income		Monthly pension	
More than—	But equal to or less than—	Present law	Committee bill
-----	\$300	\$74	\$80
\$300	400	73	80
400	500	72	78
500	600	70	76
600	700	67	74
700	800	64	72
800	900	61	69
900	1,000	58	66
1,000	1,100	55	63
1,100	1,200	51	60
1,200	1,300	48	57
1,300	1,400	45	54
1,400	1,500	41	51
1,500	1,600	37	47
1,600	1,700	33	43
1,700	1,800	29	39
1,800	1,900	23	35
1,900	2,000	17	30
2,000	2,100	-----	24
2,100	2,200	-----	21
2,200	2,300	-----	18

TABLE 7.—*Widow with one child*

Annual income		Monthly pension	
More than—	But equal to or less than—	Present law	Committee bill
-----	\$600	\$90	\$97
\$600	700	89	96
700	800	88	95
800	900	87	94
900	1, 000	86	93
1, 000	1, 100	85	92
1, 100	1, 200	83	91
1, 200	1, 300	81	89
1, 300	1, 400	79	87
1, 400	1, 500	77	85
1, 500	1, 600	75	83
1, 600	1, 700	73	81
1, 700	1, 800	71	79
1, 800	1, 900	69	77
1, 900	2, 000	67	75
2, 000	2, 100	65	73
2, 100	2, 200	63	71
2, 200	2, 300	61	69
2, 300	2, 400	59	67
2, 400	2, 500	57	65
2, 500	2, 600	55	63
2, 600	2, 700	53	61
2, 700	2, 800	51	59
2, 800	2, 900	48	57
2, 900	3, 000	45	55
3, 000	3, 100	43	53
3, 100	3, 200	41	51
3, 200	3, 300	-----	49
3, 300	3, 400	-----	47
3, 400	3, 500	-----	45
3, 500	3, 600	-----	42

EFFECT OF COMMITTEE BILL

The effect of the committee bill is illustrated in the following examples.

A veteran with no dependents who received a social security benefit of \$85.90 in December 1969, was eligible for a pension of \$88, for a total monthly income of \$173.90. The Congress increased his social security benefit to \$98.80 in 1970. Under present law, his monthly pension would be cut \$4 in January 1971, for a total income of \$182.80. Under the committee bill, not only would his pension not be cut—it would actually be increased \$2. Thus, the veteran would get both the full benefit of his social security increase plus an additional small increase in his pension for a total income of \$188.80.

A married veteran whose social security benefit in December 1969, was \$112.70 was eligible for a \$103 monthly veterans' pension, for a total income of \$215.70. The Congress increased his social security benefit to \$129.60 in 1970. Under present law, his pension will be cut to \$101 next January, making his total income \$230.60. Under the Committee bill, his pension will be increased to \$110 instead of cut, and he will have the full benefit of the social security increase plus a \$7 pension increase for a total income of \$239.60.

A widow with one child whose monthly social security benefit in December 1969, was \$106 was eligible for an \$83 widow's pension for a total income of \$189. The Congress increased her social security benefit to \$122 in 1970. Under present law her pension would drop to \$79 in January 1971, bringing her total income to \$201. Under the committee bill, her pension will not be cut, but instead will be raised to \$85, giving her the full benefit of her social security benefit increase and raising her total income to \$207.

DEPENDENCY AND INDEMNITY COMPENSATION FOR PARENTS

Present law provides monthly benefits to the survivors of veterans whose death was related to their military service. Benefits to widows of these veterans were most recently increased in 1969.

The parents of a serviceman or veteran whose death was service-connected may also receive dependency and indemnity compensation. Like pension benefits for veterans and widows, dependency and indemnity compensation payments to parents are related to the income of the parents. The Committee bill would provide increases in the parents' dependency and indemnity compensation schedules as shown in the tables below:

TABLE 8.—*Dependency and indemnity compensation payments to parents of deceased veterans or servicemen whose deaths are service connected*

[1 parent]

Annual income		Monthly payment	
More than—	But equal to or less than—	Present law	Committee bill
-----	\$800	\$87	\$94
\$800	900	81	90
900	1, 000	75	86
1, 000	1, 100	69	82
1, 100	1, 200	62	76
1, 200	1, 300	54	69
1, 300	1, 400	46	62
1, 400	1, 500	38	55
1, 500	1, 600	31	48
1, 600	1, 700	25	41
1, 700	1, 800	18	34
1, 800	1, 900	12	28
1, 900	2, 000	10	22
2, 000	2, 100	-----	16
2, 100	2, 200	-----	14
2, 200	2, 300	-----	12

TABLE 9.—*Dependency and indemnity compensation payments to parents of deceased veterans or servicemen whose deaths are service connected*

[2 parents not living together]

Annual income other than DIC		Monthly payment, each parent	
More than—	But equal to or less than—	Present law	Committee bill
-----	\$800	\$58	\$63
\$800	900	54	61
900	1, 000	50	58
1, 000	1, 100	46	54
1, 100	1, 200	41	51
1, 200	1, 300	35	47
1, 300	1, 400	29	42
1, 400	1, 500	23	37
1, 500	1, 600	20	32
1, 600	1, 700	16	28
1, 700	1, 800	12	24
1, 800	1, 900	11	21
1, 900	2, 000	10	18
2, 000	2, 100	-----	15
2, 100	2, 200	-----	13
2, 200	2, 300	-----	12

TABLE 10.—*Dependency and indemnity compensation payments to parents of deceased veterans or servicemen whose deaths are service connected*

[2 parents living together]

Combined annual income other than DIC		Monthly payment, each parent	
More than—	But equal to or less than—	Present law	Committee bill
-----	\$1, 000	\$58	\$63
\$1, 000	1, 100	56	62
1, 100	1, 200	54	60
1, 200	1, 300	52	58
1, 300	1, 400	49	56
1, 400	1, 500	46	54
1, 500	1, 600	44	52
1, 600	1, 700	42	50
1, 700	1, 800	40	48
1, 800	1, 900	38	46
1, 900	2, 000	35	44
2, 000	2, 100	33	42
2, 100	2, 200	31	40
2, 200	2, 300	29	38
2, 300	2, 400	26	36
2, 400	2, 500	23	34
2, 500	2, 600	21	32
2, 600	2, 700	19	30
2, 700	2, 800	17	28
2, 800	2, 900	15	26
2, 900	3, 000	12	24
3, 000	3, 100	11	22
3, 100	3, 200	10	20
3, 200	3, 300	-----	18
3, 300	3, 400	-----	16
3, 400	3, 500	-----	14
3, 500	3, 600	-----	12

COST

The Veterans' Administration estimates that the committee bill would increase pension and dependency and indemnity compensation payments by \$160 million over present law in the first full year of effectiveness.

X. MISCELLANEOUS AMENDMENTS

Miscellaneous Amendments

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X. MISCELLANEOUS AMENDMENTS

A. TAX AMENDMENTS

DENIAL OF TAX DEDUCTION WITH RESPECT TO CERTAIN MEDICAL REFERRAL PAYMENTS

(Sec. 602 of the bill and sec. 162(c) (2) and (3) of the Code)

Present law.—As a result of the Tax Reform Act of 1969, present law provides that no tax deduction is to be available for illegal bribes or kickbacks paid where, as a result of the payments, there is successful criminal prosecution.¹ If the bribe or kickback does not constitute a criminal act (presumably even if there is a loss of license), or if the taxpayer is not successfully prosecuted, a deduction is available.

In 29 States, medical referral payments are not illegal and, therefore, are clearly deductible under present law. In the remaining 21 States, medical referral fees by physicians are classified as constituting unprofessional conduct and are grounds for revocation of licenses to practice medicine.

The pre-1969 law did not generally state that bribes and kickbacks were not deductible. However, the courts, in effect, denied deductions for payments which were held to be contrary to "public policy." In 1952, the Internal Revenue Service ruled that medical referral payments were generally deductible if they did not "frustrate sharply defined National or State policies evidenced by a governmental declaration proscribing particular types of conduct." While what constituted "public policy" was by no means a settled matter, it is likely that if a State were to revoke a license to practice medicine because of the payment of a medical referral fee, the payment would have been held by the courts to be contrary to public policy. As a result, if the Internal Revenue Service had denied a deduction for a medical referral payment where a license was revoked, it is quite likely that the courts would have upheld the Service. On the other hand, under pre-1969 law, the *Lilly* case refused to deny a deduction for referral payments in the case of opticians where the payments, although questionable ethically, were not illegal or grounds for revocation of license.

General reasons for change.—The committee, when it adopted the provision relating primarily to treble damage payments in the consideration of the Tax Reform Act of 1969, did not intend to relax the deductibility rules in the case of medical referral payments. Such payments are considered to be unethical by the American Medical Association, and their deduction for tax purposes is inimical with public policy.

¹ A separate rule is provided illegal payments to Government officials. Illegal payments to them are not deductible whether or not there is a successful prosecution. However, in these cases the burden of proof is on the Government to the same extent as in a fraud case.

The difficulty in dealing with this problem lies in the fact that these payments under pre-1969 law, although they may not have been deductible in 21 States, probably were deductible in the remaining 29 States where the payments were not grounds for revocation of the license to practice medicine. Since professional conduct is a matter generally regulated by State law, it seems inappropriate for Congress to make all medical referral payments as a general rule nondeductible.

The Federal Government, however, is directly involved in the field of medical payments to the extent of payments made under either the medicare or medicaid programs. Medical referral payments, where the compensation is provided by the Federal Government through the medicaid or medicare programs, are made criminal acts by section 273 of the bill and, therefore, on this ground would, even under the 1969 Act, not be deductible for tax purposes if there were successful criminal prosecution. However, the committee believes that merely making medical referral payments illegal under the medicare and medicaid programs does not fully effectuate the desired policy in this area, since the requirement of a criminal conviction contained in present law has the effect of unduly limiting the number of deductions for medical referral payments which are disallowed.

Explanation of provision.—The bill deletes the requirement in present law (sec. 162(c)(2)) which requires a conviction in the case of bribes and kickbacks before a deduction for them is denied. Instead the bill provides for the denial of a deduction in the case of bribes and kickbacks which are illegal either under Federal or State law if these laws subject the party involved to liability for criminal or civil penalties (including the loss of license). In the case of a payment which is illegal under State law, the deduction will be denied on the basis of such illegality only if the law is generally enforced. The bill makes clear that referral fees are to be treated as bribes or kickbacks for purposes of the disallowance provision.

REQUIRED INFORMATION RELATING TO EXCESS MEDICARE TAX PAYMENTS BY RAILROAD EMPLOYEES

(Sec. 603 of the bill and sec. 6051 of the Code)

Present law.—Under present law as provided by the Social Security Amendments of 1967, a railroad employee or railroad representative whose work is covered by railroad retirement and who is also employed in other work covered by social security is entitled to receive a credit or refund of the excess medicare tax he may have paid because of this dual employment status. To inform an employee of his compensation covered by railroad retirement and the hospital tax deducted from it, the 1967 Amendments required railroads to include on the W-2 forms (which must be furnished to employees by January 31 of each year), the amount of wages paid subject to railroad retirement, the amount of railroad retirement tax deducted from these wages, and the portion of the tax attributable to hospital insurance (medicare). With this information it was presumed that he would be aware of his refund rights and thereby claim them as a credit on his return.

General reasons for change.—Unfortunately, the present information requirement cannot readily be complied with by the railroads in time to meet the January 31 date. The railroads' inability to furnish this

information by January 31 results from the fact that the wage concept under railroad retirement is different from the wage concept for Federal income tax purposes. Adjustments required in arriving at railroad retirement compensation (which is determined on a monthly basis for any year), cannot be readily made in the 31-day period following the close of the calendar year. Also, the railroads cannot identify the relatively few employees who might be eligible for refunds and thus must necessarily supply the information on the W-2 forms to all their employees, which number about 580,000.

Explanation of provision.—In view of the problem described above, the committee decided to delete the provision of present law requiring railroads to supply separate hospital tax information on the W-2 forms for their employees. This is accomplished by deleting the reference to section 3201 in section 6051(a) and by striking out paragraphs (7) and (8) in that subsection. In addition, the reference to section 3201 is deleted from section 6051(c).

In place of supplying the separate hospital tax information generally on all W-2 forms, the bill requires that railroad employers include on, or with, these forms a notification that any person who has a second employment, in addition to his railroad employment, may be eligible for a credit or refund of any excess medicare tax which he might have paid because of employment under both social security (including employee and self-employment coverage) and railroad retirement. This is provided by adding a new subsection (e)(1) to section 6051.

In addition, railroad employers, in the case of individuals having this dual railroad retirement and Social Security coverage, are, upon the request of the employee, to furnish him a written statement showing the amount of railroad tax coverage, the total amount deducted as tax, and the portion of the total amount which is for the financing of the cost of hospitalization insurance under part A of title XVIII of the Social Security Act.

This limits to a relatively small number the cases where the additional information needs to be supplied.

The amendments made by this provision apply to remuneration paid after December 31, 1969.

REPORTING OF MEDICAL PAYMENTS

(Sec. 604 of the bill, sec. 6050A of the Code, and sec. 1122 of title XI of the Social Security Act)

Present law.—Under present law, a person making specified kinds of payments in the course of a trade or business to another person, amounting to \$600 or more in a calendar year, must file an information return showing the amounts paid and the name, address and identifying number of the recipient. In November, 1969, the Internal Revenue Service announced a ruling applying this reporting requirement to payments under medical insurance plans and medical assistance programs. Under the ruling, insurance companies (including those participating in medicare), Blue Cross-Blue Shield organizations, State agencies participating in medicaid, and unions and employers with self-insured or self-administered plans must make information returns with respect to payments to doctors, dentists, and other providers of

health care services. Before the ruling, payments to providers of health care services ordinarily were not required by the Internal Revenue Service to be reported on information returns, although such reporting was authorized.

General reasons for change.—The Treasury Department testified before the committee and recommended that its authority to require reporting of medical payments be expanded. Although organizations are required under the ruling to report direct payments (often described as “assigned” payments) to providers of health care services, there is no authority under present law to require the reporting of payments made to the patients themselves (“unassigned” payments), even though in normal circumstances they are paid over to providers of health care services, or represent reimbursement of earlier payments to providers. The Treasury recommended that it be given the authority to require reporting of unassigned payments. In this connection it should be noted that the reporting requirement itself can be expected to have a salutary effect. The Treasury testified before the committee that past experience has demonstrated that information reporting can greatly increase the level of voluntary reporting of income. It said that from 1960 to 1963 the number of individual income tax returns reporting interest income increased more than 100 percent, and reported interest increased from \$5.1 to \$9.2 billion, largely as a result of the reduction of the level of information reporting on interest from \$600 to \$10 per year. On the other hand, representatives of the insurance industry testified that reporting of unassigned payments would be very costly in relationship to the benefits expected to be derived.

In view of the above considerations, the committee decided to provide specifically for the payments made to providers of health care services in the case of “assigned” (direct) payments. In the case of “unassigned” (indirect) payments, it decided that it was appropriate to require reporting in those cases where the Federal Government administers the program or funds it to a substantial extent.

The Treasury Department also recommended in its testimony that it be given specific authority to require reporting of payments to professional service corporations, proprietary hospitals and other providers of health care services and to impose a requirement on these organizations to report subsequent payments by them to other providers of health care services. The Treasury also asked for specific authority to require that payers furnish to providers the information reported to the Internal Revenue Service. The committee concurred in these recommendations.

Explanation of provisions.—With respect to assigned (direct) payments, the bill would specifically require the reporting of payments made to providers of health care services, beginning with the calendar year 1971. This provision codifies the existing ruling.

With respect to unassigned (indirect) payments, reporting is limited to payments under Government health care programs, such as medicare, medicaid, and the Federal employees health benefits program. In the case of unassigned payments, the paying organization would be required to report not the amount actually paid to the insured, but the amount shown on the bills submitted by the insured in support of his claim. Reporting with respect to unassigned payments is to begin with calendar year 1972.

The committee was concerned that limiting the reporting of unassigned payments to payments under Government programs might lead to widespread shifts from assigned to unassigned payments, to the detriment of the patient, where a Government program is not involved. The committee resolved its concern by adding a provision to the bill directing the Secretary of the Treasury and the Secretary of Health, Education, and Welfare to study the pattern of billings to determine the extent to which there is a shift from assigned to unassigned payments and to report their findings each year to the committee and to the House Committee on Ways and Means. Should a significant shift occur, the question whether reporting should be required with respect to *all* unassigned payments will be reconsidered.

As under present law, the reporting requirement is to apply only if the aggregate payments to a provider during the calendar year exceed \$600. However, assigned and unassigned payments are to be aggregated separately, and a separate \$600 minimum is to apply to each category. It is anticipated that the Treasury Department will provide by regulation that payers may report all amounts, if they wish to do so, without regard to the \$600 limitation.

The reporting requirements are not to apply to payments to tax-exempt hospitals or other organizations described in section 501(c)(3) and exempt from taxation under section 501(a), or to agencies or instrumentalities of the United States or of any State or political subdivision.

The reporting requirements are not to apply to a payment made by an individual for health care services furnished to himself or any other individual, unless the payment is made in the course of a trade or business. Thus, although the requirement applies to an insurance company that pays an insured patient's doctor bill, it does not apply to the patient himself when he pays a doctor bill, because he is not **making** the payment in the course of a trade or business.

The reporting requirements also are not to apply to the payment of wages subject to withholding by an employer, if they are reported on a Form W-2 or other statement under section 6051.

The bill authorizes the Secretary of the Treasury or his delegate to establish other exceptions by regulation.

For purposes of the reporting requirements, "health care services" are defined by reference to the services to which the medicare and medicaid provisions apply, and include such other similar or related services as the Secretary or his delegate may prescribe by regulations. The definition includes medical and dental services, and various related items of personal property, including drugs and biologicals.

A "provider of health care services" is defined as a person who furnishes health care services, unless his services are principally the selling or leasing of personal property (such as drugs and biologicals). For example, doctors, dentists, nurses, medical technicians, hospitals, and clinics are providers of services, but proprietary pharmacies and organizations renting health care equipment usually are not.

The bill also provides a definition of Government health care programs, since reporting with respect to unassigned payments is required only with respect to payments under Government programs. "Government health care program" means any program for providing

health care services which is administered by any Department, agency or instrumentality of the Government of the United States or is funded to a substantial extent by the United States. The term includes the medicare and medicaid programs and programs for maternal, child health, and crippled children services (under titles V, XVIII, and XIX of the Social Security Act), the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code), military health benefits (under chapter 55 of title 10, United States Code), and veterans benefits (under chapter 17 of title 38, United States Code).

The reporting requirements apply to payments made by the United States, any State or political subdivision, or any of their agencies or instrumentalities. The returns required of these governmental units are to be made by the officers or employees having information as to the payments.

The bill requires every person who makes a return to furnish each person whose name is set forth in the return a written statement showing the name and address of the person making the return and the total amounts reported with respect to assigned and unassigned payments. The statement is to be furnished on or before January 31 of the year following the calendar year for which the information return was made.

The bill also requires a provider of health care services to furnish, upon request of the payer, his address (and, if different, the address used for purposes of filing his income tax return) and his identifying number. This information must be furnished whether or not assigned payments, or amounts paid or payable with respect to unassigned payments, total \$600 or more at the time the request is made.

The payer is required to retain records with respect to the information shown on the return, and to make the records available to the Secretary or his delegate.

The committee also agreed that it was appropriate for the Internal Revenue Service to supply insurance companies making assigned or unassigned payments the names, addresses, and identifying numbers of doctors and others covered by this provision. The names, addresses, and identifying numbers provided the insurers for this purpose, however, are not to be used by them for any other purpose.

The bill also amends title XI of the Social Security Act to require the Secretary of Health, Education, and Welfare to provide for similar reporting with respect to medicare and medicaid payments. Beginning with calendar year 1970, the Secretary is required to keep records showing the identity of each provider of medical or health care items or services who receives payments under medicare and medicaid programs, and under programs for maternal, child health, and crippled children services (under title V of the Social Security Act), the types of items or services rendered, and the aggregate amounts paid to the providers under each program. In order to carry out this requirement, the Secretary is given the authority to require information from all persons, agencies, or agents administering or assisting in the administration of these programs. The providers are required to be identified by their identifying numbers.

The bill requires the Secretary of Health, Education, and Welfare to submit to the Senate Committee on Finance and the House Com-

mittee on Ways and Means an annual report identifying each person paid a total of \$25,000 or more during the preceding year under medicare, medicaid, and title V programs. Reports must be submitted for the calendar year, beginning with 1970, not later than June 30 of the following calendar year. These reports will facilitate the committees' exercise of their legislative responsibilities with respect to these programs.

RETIREMENT INCOME CREDIT

(Sec. 611 of the bill and sec. 37 of the Code)

Present law.—Present law provides a retirement income credit to taxpayers age 65 or older or who retired under a public retirement system. The credit is 15 percent of eligible retirement income up to \$1,524 for single persons and up to \$2,286 for married taxpayers, both of whom are age 65 or over for a maximum credit of \$228.60 and \$342.90, respectively. The maximum base for the credit is reduced by the amount of social security, railroad retirement, and other tax exempt benefits. Because social security and railroad retirement benefits are tax-exempt, the retirement income credit was designed to provide approximately equal tax treatment for taxpayers that receive retirement income in a form other than social security and railroad retirement. In addition, the maximum base of the credit for persons between age 62 and 72 is reduced by earned income in excess of \$1,200—a reduction of 50 cents for each dollar of earnings between \$1,200 and \$1,700, and on the basis of a dollar for each dollar of earnings above \$1,700.¹

General reasons for change.—When the retirement income credit was enacted into law in 1954, the maximum amount of retirement income which could then qualify for the credit (\$1,200) was equal to the annual maximum amount which could be received in social security benefits. (Similarly, the amount of nonretirement income which could be received without reduction of the tax credit was approximately equal to the amount of non-retirement income which could be received by recipients of social security without a reduction in social security benefits). Although social security benefits were subsequently increased, the maximum amount of retirement income available for the credit was not changed until 1962. In 1962, the maximum limit of the credit for an individual was increased to \$1,524 to correspond with the maximum social security benefits enacted in 1958. In 1964, a corresponding increase in the maximum limit of the credit to \$2,286 was provided for married couples. Since then the maximum and average social security benefits have been raised substantially, increasing the difference between social security benefits and the maximum base for the retirement income credit.

The committee concluded that the gap between the level of social security benefits and the base for the retirement income credit has become excessive. As a result, it concluded that the maximum base for the credit should be brought more nearly in line with current levels of social security benefits. The new base provided for the retirement

¹ For taxpayers under age 62 (who have retired under a public retirement system), the base for the credit is reduced dollar for dollar by earnings in excess of \$900. For taxpayers age 72 or over, the base is not reduced by earnings.

credit is not as high as the maximum social security benefits provided by the bill, however, in recognition of the fact that most social security beneficiaries—with whom the analogy is usually made—also do not receive maximum benefits. The new base for the retirement credit, however, is well above the average social security benefits provided by the bill.

In addition, the committee concluded that it would be appropriate also to increase the earnings levels above which the base for the credit is reduced. Here, too, the bill aligns these levels more closely with the current amounts social security recipients may earn without a reduction (or with a 50-percent reduction) in benefits.

Explanation of provision.—The bill increases the maximum base for the retirement income credit from \$1,524 to \$1,872 for a single individual (sec. 37(d) of the Code), and from \$2,286 to \$2,808 for qualifying married couples (sec. 37(i) of the Code). This increases the maximum credit from \$228.60 to \$280.80 for a single person and from \$342.90 to \$421.20 for qualifying married couples. The amount that can be earned without reduction in the base for the credit (sec. 37(d) (2) (B) of the Code) is raised from \$1,200 to \$1,680. Similarly, the earnings which may be received in the range where the credit base is reduced 50 cents for each dollar of earnings is increased from the previous \$1,200 to \$1,700 range to a range of \$1,680 to \$2,880. This also means that the level of earnings which reduce the credit base dollar for dollar is raised from \$1,700 to \$2,880.

The effective date of this provision is taxable years beginning after December 31, 1970.

This provision is estimated to provide tax reduction of \$85 million annually.

TAX CREDIT FOR PORTION OF SALARY PAID PARTICIPANTS IN WORK INCENTIVE PROGRAM

(Sec. 612 of the bill and secs. 40, 50, and 50A of the Code)

When the Work Incentive (WIN) Program was enacted in 1967, Congress and the Labor Department were optimistic that it would help relieve the incidence of dependence on welfare by training welfare recipients to qualify for gainful employment. It was an effort to aid recipients in getting off the welfare rolls and onto payrolls.

For many reasons, however, WIN has not been as successful as was originally envisioned. Other amendments in the bill, described in part VIII of this report, seek to modify the WIN program to make it a more effective tool in leading welfare recipients to economic independence.

It is clear that improvements in the operation of the Work Incentive Program will be insufficient by themselves if jobs in the private sector are not available for WIN participants. Therefore, the committee bill would add a special tax credit provision to encourage employers in the private sector to set up on-the-job training programs for and hire welfare recipients participating in the Work Incentive Program.

The committee believes that the dual approach of improving the WIN program on the one hand and seeking greater employer partici-

pation in the program on the other—the latter by allowing this tax credit—will be of great benefit in matching up jobs and welfare recipients. It is convinced that whatever revenue loss is occasioned by enactment of the tax credit will be more than offset by reductions in welfare appropriations as recipients move from welfare to workfare.

The amount of the credit which would be allowed against an employer's income tax liability would be equal to 20 percent of the wage or salary of an individual in on-the-job training or placed through the WIN program during the first 12 months of his employment. As a further incentive to hire individuals covered by the work incentive program, the tax credit would be in addition to the present deduction for business expenses (which includes employee training costs).

Explanation of Provision.—Under this provision, a taxpayer is to be allowed as a credit against his income tax liability for the taxable year an amount equal to 20 percent of "work incentive program expenses" which he has paid or incurred during the year. However, the credit for a taxable year may not exceed \$25,000 plus 50 percent of the taxpayer's income tax liability in excess of \$25,000. "Work incentive program expenses" are defined as the wages and salaries attributable to the first 12 months of employment of employees who are placed in on-the-job training or employment under a work incentive program established under section 432(b)(1) of the Social Security Act. The amendment makes clear that the credit is not to be available with respect to wages or salaries paid to domestic employees. On the contrary, it is provided that only wages and salaries paid in the course of a trade or business are to qualify.

If the taxpayer terminates the employment of an employee placed under the work incentive program at any time during the first 12 months of employment or at any time during the next 12 months after the first 12 months of employment have been completed, then any tax credit allowed under this provision for the employee is to be recaptured. The tax liability of the taxpayer, for the year of termination, is increased by an amount equal to previous tax credits allowed for work incentive program expenses incurred with respect to the employee. The recapture provision is not to apply if the employee voluntarily leaves the employment of the taxpayer or if the employee becomes disabled.

This provision also permits any unused tax credits under this section to be carried back three taxable years and then to be carried forward seven taxable years. The unused credit carryback may be used to reduce any income tax liability for the years to which it is carried. However, any unused credit for a year may only be carried back to a taxable year beginning after December 31, 1968.

The provision contains several limitations. A credit may not be taken for work incentive program expenses which do not qualify as deductible trade or business expenses, or if the expenses have been reimbursed to the taxpayer. Further, the credit would not be allowed for any expenses of training conducted outside the United States. Also, no work incentive program expenses on behalf of an employee may be used in computing the credit if the expenses are incurred after the end

of the 24-month period beginning with the date of initial employment by the taxpayer. In addition, no work incentive program expenses may be taken into account with respect to an employee who is closely related to the taxpayer. If the taxpayer is a corporation, estate or trust, special rules are provided to achieve a similar result.

The provision is to be effective for taxable years beginning after December 31, 1970.

REFUND OF SOCIAL SECURITY TAX TO MEMBERS OF CERTAIN RELIGIOUS FAITHS OPPOSED TO INSURANCE

(Sec. 128 of the bill and sec. 6413 of the Code)

The committee bill extends an exemption (by a refund or credit against income taxes at yearend) from the employee portion of social security taxes to members of certain religious sects who have conscientious objections to social security by reason of their adherence to the established teachings of the sect. The employee is required to file an application for exemption from the tax and would have to waive his eligibility for social security and medicare benefits. The provision specifically states that there would be no forgiveness of the employer portion of the social security tax as the committee believes that this would create an undesirable preference in the statute.

This exemption (refund) is more fully described in part III of this report.

B. OTHER AMENDMENTS

APPOINTMENT AND CONFIRMATION OF ADMINISTRATOR OF SOCIAL AND REHABILITATION SERVICE

(Sec. 605 of the bill)

The Social and Rehabilitation Service was established in 1967 by a reorganization within the Department of Health, Education, and Welfare. Its responsibilities are broad, encompassing the Federal welfare programs, medicaid, and programs in the areas of vocational rehabilitation, aging, and juvenile delinquency. The sums involved are huge; these programs accounted for expenditures totaling \$9 billion in fiscal year 1970. The bulk of the funds are spent on the public assistance and medicaid programs.

The size of the budget is not the only indication of the responsibilities of the Administrator of the Social and Rehabilitation Service and the commissioners of the bureaus under him. For the Administrator is the agency's top official in formulating policy for such important programs as medicaid and the work incentive program aimed at helping assistance recipients to become economically independent.

At present, three agency heads in the Department of Health, Education, and Welfare with stature equivalent to that of the Administrator of the Social and Rehabilitation Service—the Commissioner of Social Security, the Commissioner of Education, and the Surgeon General of the Public Health Service—all are nominated by the President with the Senate's advice and consent. In fiscal year 1970, the expenditures of the Social and Rehabilitation Service exceeded those of the Office

of Education and Public Health Service combined. The committee bill would end the present anomaly by treating all four agency heads equally. The bill would upgrade the stature of the Administrator of the Social and Rehabilitation Service by having the President select him and by giving him the support of the Senate that his colleagues now enjoy.

ADVISORY COUNCIL REPORTING DATE

(Sec. 606 of the bill)

In order to provide the current Advisory Council on social security with an opportunity to modify its report so as to take into account social security legislation enacted toward the end of this year, the committee bill would extend the life of the Council for 2 months by requiring that its report be submitted not later than March 1, 1971, rather than by January 1, 1971.

The current members of the Council and its Chairman are expected to continue to serve on the Council until the Council concludes its deliberations and its reports are transmitted to the Congress. It is assumed that a change, occurring in the last weeks or months of the Council's deliberations, in the status which was the basis or a basis for a member's appointment to the Council will not preclude such member from continuing to serve until the Council submits its report.

PASS-ALONG TO WELFARE RECIPIENTS OF INCREASES UNDER 1969 SOCIAL SECURITY AMENDMENTS

(Sec. 608 of the bill)

The Social Security Amendments of 1969 included a provision to assure that recipients of aid to the aged, blind, and disabled would be allowed to keep at least a portion of the social security benefit increases which that act provided effective in 1970. This provision prohibited States from offsetting the full amount of those increases with corresponding reductions in welfare grants. Instead, the act required that each recipient be assured that his total monthly income would be raised by at least \$4 or (if less) by the amount of his social security benefit increase. Originally, this pass-along provision was to have expired at the end of June 1970. Subsequent legislation extended the provision through October 1970 and also made it applicable to welfare recipients who received an increase this year in railroad retirement benefits. The committee bill provides a further extension of the provision through the end of 1971.

Though the social security benefit increase in this bill is effective as of January 1, 1971, it is expected that due to processing time, checks reflecting the increase will not be issued until April 1971. During that month, a second check will be mailed out containing the increases not included in the checks for the first months of 1971. The committee bill also requires States to disregard, for public assistance purposes, the retroactive benefit increase check mailed out in April.

GRADE LEVEL FOR COMMISSIONER OF SOCIAL SECURITY

(Sec. 613 of the bill)

At the present time the Commissioner of Social Security is at level V of the Executive Schedule (salary \$36,000 per year), as is his deputy. In contrast, other similar positions in the Department of Health, Education, and Welfare are at level IV of the Executive Schedule (salary \$38,000 per year) while their deputies are at level V, one grade lower. The duties of the Commissioner of Social Security—both in terms of the number of employees and responsibilities for supervising expenditures of public funds—is much greater than any comparable position in the Department of Health, Education, and Welfare. For example, the Commissioner of Social Security is responsible for expenditures of about \$45.7 billion a year—about 70 percent of the expenditures in the entire Department—53,000 employees—about one-half of all the employees in the Department. In contrast, the higher graded Administrator of the Health Services and Mental Health Administration is responsible for expenditures of about \$1.5 billion and 25,400 employees; the Director of the National Institutes of Health is responsible for expenditures of about \$1.5 billion and for 11,400 employees; the Administrator of the Social and Rehabilitation Services is responsible for expenditures of about \$9.2 billion and for 1,900 employees.

In recognition of the high-level responsibilities of the Commissioner of Social Security and to preserve a grade-level separation between him and his deputy, the committee bill contains a provision which would place the position of Commissioner of Social Security at level IV of the Executive Schedule which is one grade higher than the grade level of his deputy.

AUTHORIZATION FOR THE MANAGING TRUSTEE OF THE SECURITY TRUST FUNDS TO ACCEPT MONEY GIFTS MADE UNCONDITIONALLY TO THE SOCIAL SECURITY ADMINISTRATION

(Sec. 609 of the bill)

There is no authorization in the law for the managing trustee of the social security trust funds (by law, the Secretary of the Treasury) to accept gifts and bequests made to any of the social security trust funds. While unrestricted bequests can be deposited in the general funds of the Federal Government, bequests restricted to any of the social security trust funds cannot be accepted without enactment of special legislation.

There is precedent in the law for the Government to accept gifts for special purposes. The Secretary of Health, Education, and Welfare can accept gifts for certain divisions of the public health service, such as the National Library of Medicine, the National Cancer Institute, or the National Heart Institute, St. Elizabeths Hospital, and the Cuban refugee program.

There have been some cases where money has been bequeathed to the social security trust funds. Because such a bequest cannot be accepted, confusion and delay in settling the estate may result. The

Department points out that while the amount of money lost to the trust funds is insignificant, it seems unjustifiable that an act presumably motivated by appreciation for, and confidence in, a Government program should cause complicated and perhaps interminable legal problems for the survivors.

The committee bill, therefore, adds a new provision to the House-passed bill to authorize the managing trustee of the social security trust funds to accept money gifts made unconditionally and to deposit them in the social security trust funds.

Under this amendment, gifts would be credited to the particular trust fund designated by the donor (the old-age and survivors insurance trust fund, the disability insurance trust fund, the hospital insurance trust fund, or the supplementary medical insurance trust fund). If no fund is designated, the gift would be credited to the old-age and survivors insurance trust fund.

LOANS TO SUPPLY FUNDS TO ASSIST HOSPITALS AND EXTENDED CARE FACILITIES TO MEET REQUIREMENTS OF LIFE SAFETY CODE

(Sec. 610 of the bill)

A relatively small number of hospitals and extended care facilities, constructed of combustible materials, are required to be equipped with automatic sprinklering systems in order to participate in Medicare and Medicaid. Some of these institutions do not presently have such systems and have been permitted to participate in medicare with the understanding that they would install them as soon as possible. Some have been unable to do so because of the lack of funds, as well as the unavailability of sources to which they might look for loans on reasonable terms.

In order to help those institutions presently providing necessary care to a substantial proportion of beneficiaries in the area who need such care, and continue to meet the needs of beneficiaries who would not otherwise have access to needed care without these institutions, the committee bill would authorize the Secretary of Health, Education, and Welfare to approve loans for the purpose of installing sprinklering systems which meet the requirements of the Life Safety Code of the National Fire Protection Association. Loans would be authorized during the period ending December 31, 1975, but only where the appropriate State planning agency finds that the proposed loan should be made to permit the continued participation in Medicare of an institution that was participating in the program on January 1, 1971 and that the proposed investment would not be inconsistent or inappropriate in terms of area needs for the facility concerned. Thus, loans would be made for existing structures only.

Loans would be made only after a finding by the Secretary that the institution is unable to raise the required funds internally, and is unable to obtain a loan at a reasonable rate of interest and on reasonable terms from other sources. The amount of the loan may not exceed an amount that can reasonably be expected to be repaid by the institution.

The interest charged on such loans will be at the average rate of return on assets of the hospital insurance trust fund at the time the loan is made. Loans are to be repaid over a period not to exceed 10 years, in equal periodic payments no less frequently than annually. The loan will become due and payable in full at any time that the facility no longer affords services to a reasonable proportion of Medicare beneficiaries in the area who require such services or if the funds are not used for the purpose intended. Funds necessary for such loans are authorized to be appropriated from the general revenues of the Federal government.

The committee expects that the Secretary, in considering whether to terminate an institution's participation in Medicare by reason of its failure to install a required automatic sprinklering system because of the lack of funds, will take into account the opportunity here provided to obtain such loans on favorable terms, as well as the likelihood that the institution will apply for such a loan and that it would be approved by both the State agency and the Secretary.

XI. CHANGES IN EXISTING LAW

In the opinion of the committee, it is necessary, in order to expedite the business of the Senate, to dispense with the requirements of subsection 4 of rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing laws made by the bill, as reported).



**SEPARATE AND ADDITIONAL VIEWS OF MEMBERS
OF THE COMMITTEE ON FINANCE**

**Separate and additional views of members of the Committee
on Finance**
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XII. SEPARATE VIEWS OF MR. FULBRIGHT

Notwithstanding my strong support for title I of H.R. 17550 containing increases in social security benefits, I voted in Finance Committee against reporting this legislation in its present form. As now constituted, the bill contains, in addition to social security provisions, numerous medicare and medicaid amendments, some family assistance proposals, a catastrophic health insurance plan, and a major international trade package. Any one of these proposals would be considered a major piece of legislation. Aside from the merits of these provisions, it is my view that the procedural obstacles likely to result from attaching several quite different and controversial areas of legislation to the bill will jeopardize the bill's passage.

While I am not in agreement with all of the other areas of H.R. 17550 as reported it is the trade provisions which give me the most particular concern. There is substantial and respected evidence that this trade bill will portend grave foreign policy and economic consequences generally, not to mention its associated inflationary pressures.

The Finance Committee has considered an inordinate number of issues this year and, in my opinion, was not able to give adequate time to trade hearings. Considering the scope of this legislation, relatively few witnesses appeared before the committee. One witness who did testify, however, was the Secretary of State. With reference to the likelihood of this bill crippling international commerce, Secretary Rogers' forecast is bleak:

It may be said that these fears are unjustified, that the proposed legislation merely seeks to deal with certain special and urgent problems of the United States, and that other nations too have restrictions on imports. The fact is, however, that the legislation before you could lead to restrictions on a very large volume of U.S. trade, as much as \$3 billion or more, and other nations are acutely aware of this.

Statements such as this one have not been rebutted to my satisfaction, and these unanswered questions about the impact of this bill leave serious misgivings in my mind about supporting it. For example, my State depends to a great extent on agricultural exports, as evidenced by a fiscal year 1970 total of \$296 million. I must say that I have not been convinced that this bill will not adversely affect the export markets of such products as soybeans, cotton, and rice.

I am, of course, sympathetic to the problems caused by foreign imports which exist within such industries as textiles and footwear. Indeed, their plight suggests that a review of our international trade policies should be forthcoming. Such a review should, however, be comprehensive and should be undertaken with deliberation and accompanied by adequate hearings. The adjournment rush is no time to attempt to focus on a question of this magnitude.

Accordingly, I voted in committee to separate the trade amendments from the social security bill, believing such action would enhance the latter becoming law. I regret that this effort was unsuccessful.

Our senior citizens on fixed incomes are those in our society who suffer most seriously from inflation, and it seems indeed ironic that a bill designed to give needed social security increases and reform should become encumbered with, among other things, far-reaching trade proposals, the economic consequences of which could conceivably offset the originally intended benefits of H.R. 17550.

J. W. FULBRIGHT.

XIII. ADDITIONAL VIEWS OF MR. RIBICOFF

Part One—Welfare

Comprehensive welfare reform is the most urgently needed domestic legislation now being considered in Congress.

The necessary improvements have not been provided by the Senate Finance Committee amendments. Therefore, Senator Bennett and I propose a program of substantive reform to go into effect following extensive testing to assure administrative and operational efficiency.

Our proposal is based on the major provisions of the Family Assistance Plan proposed by the Administration. While our amended Family Assistance Plan does not provide everything ultimately required to perfect this nation's welfare program, it is a necessary and significant step forward.

The United States must commit itself to end poverty. Family Assistance can be a major contribution toward fulfilling that commitment.

I. THE PRINCIPLES OF REFORM

Welfare is not a subject of interest only to the poor and the welfare worker. The measure of a whole society is taken from the adequacy, equity and efficiency of its programs for the needy. Their progress is our progress.

The principles of adequate welfare are simple and paramount:

First, assurance to all members of society of an income adequate to meet their basic needs;

Second, incentives and opportunity for the employment of all citizens;

Third, encouragement and support of the basic family structure;

Fourth, a uniform system of national standards supported and financed by the federal government; and

Fifth, simple and efficient administration dedicated to assisting rather than demeaning the poor.

We are a wealthy people. As the prerequisites of citizenship have increased, so too have our responsibilities to our society and our fellow man. As a nation we can no longer tolerate a system of public assistance which fails to meet the most basic principles of humanity.

II. THE PRESENT WELFARE SYSTEM AND THE FINANCE COMMITTEE AMENDMENTS

The present public welfare system in the United States is a failure.

Assistance payments are insufficient to meet minimal needs. Family and work incentives are lacking. Eligibility is based on arbitrary categories rather than need. While Congress has established a legal right to assistance, it has provided a system which frustrates the exercise of these rights and demeans those who do exercise them.

The welfare amendments of the Senate Finance Committee have ignored these very basic failures and therefore are inadequate to the challenge of reform.

I share the view of the Committee that far-reaching and innovative social legislation should be tested thoroughly before implementation on a nationwide basis.

But, testing alone in a time of urgent need is not enough.

In August 1969, the President outlined reform legislation which, while not perfect, would take several significant and constructive steps toward a strong welfare system.

The House of Representatives passed legislation embodying the basic principles of the President's proposal—the Family Assistance Plan.

After many weeks of hearings, however, the Senate Finance Committee regrettably refused to consider this plan in detail and substituted an amendment calling merely for two years of tests.

Clearly, passage of a two year test program requiring more legislation at the end of that test period means no welfare reform until 1974 or beyond. Reform is much more urgent than that.

The proposal Senator Bennett and I intend to make provides for extensive testing in the period between enactment and the effective date of welfare reform. The most innovative proposal, to assist the "working poor", would be tested in several areas for more than a year.

Extensive pre-testing of this nature would provide more than adequate time to iron out the problems in organization and administration of Family Assistance. Furthermore, information gained from careful evaluation of *existing* "working poor" programs in six states would be readily available.

III. A PLAN OF WELFARE REFORM

The full Senate should have an opportunity this year to debate and pass on a substantive plan of welfare reform. We intend to propose such a plan.

It contains the major elements of the Family Assistance Plan first announced by the President in 1969; refined by the House of Representatives in H.R. 16311, passed on April 16, 1970; and revised further on October 13, 1970 by the Administration.

It contains substantial changes suggested in my letter to Secretary Richardson dated December 2, 1970.

The plan also couples a program of pre-testing with authorization for substantive welfare reform.

A. FAMILY ASSISTANCE

The Family Assistance Plan would provide a basic income floor for *all* families with children. Families headed by a fully employed male, the "working poor", would be included for the first time as well as all families now eligible for AFDC. The concept of a federally-supported income floor for all families in need regardless of other classifications is a forward step toward a strong welfare system.

The income floor would be computed on the basis of \$500 each for

the first two members of a family, and \$300 for each additional member, or \$1,600 for a family of four without income. The minimum Family Assistance payment would be entirely financed by the federal government.

The Family Assistance payment level would provide increased incentives to earn outside income. The FAP benefit would be gradually reduced as the family income increased. In computing the benefit, the first \$720 of income (\$60/month) would be disregarded. Each dollar of income above \$720 annually, would reduce the FAP payment by 50 cents.

TABLE 1.—FAMILY OF FOUR FAP BENEFIT

Income.....	\$0	\$500	\$720	\$1,000	\$2,000	\$3,000
FAP payment.....	1,600	1,600	1,600	1,460	960	460
Total income.....	1,600	2,100	2,320	2,460	2,960	3,460

No payments would be made above an income level of \$3,920 for a family of four.

B. STATE SUPPLEMENTARY PAYMENTS

Above the basic Family Assistance allowance, each state in which the AFDC payment level in November 1970 was higher than the Family Assistance level must supplement the FAP payment up to that level or the poverty line whichever is lower.

The federal government would share 30% of the cost of these supplements, up to the poverty level.

The states would not be required to supplement the "working poor"—intact families with an employed male—and federal sharing would not be available for states which did supplement these families voluntarily.

Special rules would apply in computing the amount of state supplementary payments. A state would be required to disregard (1) \$720 per year plus (2) one-third of the remaining income.

Thus, in a state which presently pays a family of four up to \$3,000, a family with \$2,800 income would receive a state supplement of \$1,053 in addition to FAP benefits of \$560.

TABLE 2

Earned income.....	\$2,800
Disregard	-720
Total	2,080
Disregard $\frac{1}{3}$ of \$2,080.....	-693
Total	1,387
FAP payment to family of four earning \$2,800.....	+560
Chargeable income.....	1,947
State supplement.....	1,053
Total FAP and State supplement and earnings.....	4,413

C. WORK REQUIREMENTS

Eligibility for Family Assistance benefits is conditioned on registration for manpower training and employment programs. These requirements are applicable to all members of an eligible family except:

- (a) Persons unable to engage in work by reason of illness, incapacity or advanced age;
- (b) Mothers of children under six;
- (c) Mothers or other female caretakers of a child if a male member of the family is working;
- (d) Children under 16 or a student;
- (e) A person whose presence in the home is required because of the illness or incapacity of another member of the household.

Following suggestions by Senator Talmadge, our plan establishes priorities in the placement of welfare recipients into work or training slots. These priorities are:

- (1) unemployed fathers
- (2) persons over 16, not regularly employed and not students
- (3) regularly employed persons
- (4) all others required to register

D. PENALTIES FOR REFUSAL TO WORK OR ACCEPT TRAINING WITHOUT GOOD CAUSE

If a member of a family refuses, without good cause, to accept work or training under the provisions of this program, the family cash payment under Family Assistance will be reduced by \$500. In addition, state supplementary payments will be reduced accordingly.

E. PROPOSED CHANGES IN THE FAMILY ASSISTANCE PLAN

On December 2, 1970, I communicated to the Secretary of Health, Education, and Welfare a list of ten suggested improvements in the proposed Family Assistance Plan.

These changes should be incorporated into any welfare reform legislation considered by the Senate, and most have been included in the Ribicoff-Bennett disposal.

(1) *A National Goal:*

Today, one in every eight Americans is poor. In the wealthiest nation in history, our poor outnumber the total population of Canada. More than a third of our poor are children. Many of the rest are ill, disabled or elderly.

These people are tragic evidence of our neglect, and lack of commitment to end poverty.

Our growing national affluence has not been fully shared. In a future which promises greater riches for many but continued poverty for some, we have, in the words of the President's Commission on Income Maintenance Programs, "the potential for social division unparalleled in our country".

Our failure has been a failure of commitment rather than resources. We have the means to end poverty. Let us resolve to do so.

As a beginning step, Congress must establish a national goal to end poverty in this decade.

(2) *Unemployed Parents Program:*

As passed by the House of Representatives, H.R. 16311 provided for mandatory state supplementation (with federal sharing) of families headed by an unemployed father. (AFDC-UP) Under present law, this is an optional program existing in 23 states.

In the Administration revisions of H.R. 16311, this mandatory AFDC-UP has been deleted.

I strongly support inclusion of this program—as provided by the House of Representatives and the original Administration proposal. Restoration of this provision would benefit some 90,000 families, or more than 300,000 poor people.

(3) *Restoration of the Requirements in Sec. 452 of H.R. 16311 for Using "standard of need" for Families With Income:*

In August 1969, the President, in his welfare address to the Nation, spoke strongly for the principle that no recipient would be worse off under his proposal than under existing law. Unfortunately, a subsequent revision of H.R. 16311 would adversely affect families with outside income in 22 states by reducing state supplements. Restoration of the "standard of need" provision in Sec. 452 will remedy this unwise provision.

(4) *Minimum Wage Levels for Welfare Recipients Taking Employment:*

A universally recognized objective of welfare reform, clearly stated in the President's welfare message, is the great need to move the poor from relief rolls to payrolls. Legislation toward this laudable goal, however, must not sacrifice very basic objections to providing a ready-made pool of forced labor for employers paying substandard wages.

Substandard wages perpetuate poverty. At \$1.00 an hour, a fully employed husband and father of two children falls almost \$2,000 below the barest minimum income required for his family.

Therefore, I propose that provisions be added to this reform legislation stipulating that welfare recipients required to accept work be paid a reasonable wage, preferably the basic minimum wage of \$1.60 an hour. The Ribicoff-Bennett proposal takes a major step in this direction by guaranteeing wages of at least \$1.20 an hour.

(5) *Adequate Safeguards for State and Local Employees Taken Under Federal Programs:*

There must be assurances that state and local welfare employees, who would be encompassed by the new federal program, are treated fairly with respect to their seniority, salary and pension rights earned under their previous employers.

(6) *Federal Administration of Fully Federally Financed Welfare Programs:*

Welfare reform must reduce the major inequities and complexities that result from over 50 different welfare systems with their varied forms, requirements, and regulations. In many states today, the system is operated by three separate levels of government: federal, state

and local. The redtape, inequities, and sheer complexity of these arrangements must be reduced.

Therefore, I propose that reform legislation include a provision for mandatory federal administration of all welfare programs which are 100% funded by federal monies. This provision will be a major step toward our goal of universally applied standards for all recipients.

(7) Public Service Employment:

The major goal of any public assistance program should be the provision of adequate employment opportunities permitting recipients to supplement and eventually replace welfare payments by earned wages.

Regrettably, the original Family Assistance Plan presented to Congress contained not a single job opportunity.

Senator Harris and I have suggested an amendment establishing a strong program of public service employment. Such an amendment would complement the training provisions already suggested above by assuring a greater number of jobs at the end of the training cycle.

Therefore, I propose a public service employment program for recipients of FAP benefits or state supplementation.

Under the amendment, the Secretary of Labor would enter into grants or contracts with public or private nonprofit agencies to create jobs in a wide variety of enumerated fields of benefit to the public.

Special provisions were designed to assure that such jobs are not dead-end jobs and that they offer opportunities for career advancement. The Secretary of Labor is required to review each employment record at least once every six months.

The jobs provided must meet standards with regard to health, safety, and working conditions, not jeopardize existing employment, and otherwise conform to certain protections. Wages paid must at least equal the federal minimum wage or, if higher, any applicable state or local minimum wage or the prevailing wage for such jobs in the same labor market area.

In order to encourage movement by participating individuals into regular jobs and to ensure that these jobs involve the performance of useful work, provision is made for declining federal matching over time. Ninety percent matching is provided for the first 24 months during which such employment is provided, and 80 percent thereafter.

The Secretary of Labor is obligated to expend at least \$150 million annually on such public service jobs. The funds may come from appropriations pursuant to part C of title IV of the Social Security Act or from any other funds available to the Secretary or the Department of Labor under other acts.

(8) Work Requirements for Mothers of School-Age Children:

In 1967, the Senate recognized the inherent social difficulties of forcing mothers of school-age children to accept employment. At that time, the Senate passed an amendment which exempted mothers of school-age children from required employment during the hours children are home from school.

The most cursory examination of history shows that the victims of legislation forcing mothers to work are the children of those mothers. Our own national traditions are based on the belief that the best interests of the child are best protected by its mother. The decision whether to accept employment while the child remains at home should be left solely with the mother.

While not exempting mothers of school-age children from work, the proposal of Senator Bennett and myself will guarantee that mothers of these children will only be required to work if adequate child care facilities are available. In actual fact, the work priorities practically assure that mothers of schoolchildren will not be affected by work requirements.

(9) Additional Safeguards for the Legal Rights of Welfare Recipients:

The Administration's Family Assistance legislation provided for a marked and regressive change affecting the legal rights of welfare recipients by requiring that stepfathers assume legal responsibility for their stepchildren. Most states do not impose an obligation of support on a stepfather. Generally, our federal system has left matters of domestic relations laws to the wisdom of the states. Thus, the effect of the original FAP provision was to impose a discriminatory obligation on the stepfathers of poor families. Senator Bennett and I have proposed that this unwise provision be eliminated.

(10) Adjustment of the Base Payment of FAP to Reflect Cost of Living Increases:

Administration estimates have shown that increasing the level of payment above \$1,600 for a family of four would cost approximately \$400 million annually in federal revenues for every \$100 increase in benefits.

While it is certainly preferable that the base benefits of FAP be increased, it is more important that effective reform legislation be enacted this year.

However, as the barest minimum objective, it is imperative that FAP should include a provision to reflect additional costs of living.

IV. EFFECTS OF WELFARE REFORM

A. THE COSTS OF WELFARE REFORM

The plan outlined in the preceding pages has been estimated to increase federal welfare costs by approximately \$4.3 billion.

These costs are comparable to those estimated for the Administration's original proposal and for the bill, H.R. 16311, passed by the House of Representatives earlier this year.

It is estimated that the proposal would make 24 million Americans eligible for some federal welfare assistance compared to 11.6 million now eligible under AFDC and the adult categories.

The following charts give detailed information on costs and case-loads.

TABLE 3.—*Estimated net cost*

[In billions]

Payments to Families.....	\$2.1
Fiscal Relief to States.....	.4
Adult Category.....	.9
Day Care and Training.....	.6
Administration.....	.4
Increased Costs Due to Food Stamp Check Off.....	.1
Total.....	4.3

TABLE 4

COMPARISON OF PROJECTED ELIGIBLES UNDER THE FAMILY ASSISTANCE PLAN AND PROJECTED RECIPIENTS UNDER CURRENT LAW, 1972-76 (ASSUMES 100 PERCENT FAP PARTICIPATION)¹

[Millions of persons]

	1972	1973	1974	1975	1976
Under family assistance plan:					
Persons in families eligible for FAP only.....	11.7	11.3	10.2	9.1	8.0
Persons in families eligible for FAP and State supplemental.....	9.0	9.5	10.7	12.0	13.4
Adult category recipients.....	3.3	3.5	3.6	3.8	3.9
Total.....	24.0	24.3	24.5	24.9	25.3
Under current law:					
AFDC recipients.....	9.6	10.8	12.1	13.6	15.3
Adult category recipients.....	3.2	3.4	3.5	3.7	3.8
Total.....	12.8	14.2	15.6	17.3	19.1

¹ Comparison not directly appropriate since FAP projections include all eligibles (100 percent participation) while AFDC projections show only actual recipients (reduced participation).*Revised Estimates*

The above figures are based on 100 percent participation by all eligible recipients. However, it is not realistic to assume full participation in a new welfare program. As was pointed out by Mayor Lindsay of New York before the committee, actual participation rates in New York City programs for the "working poor" are about 33 percent even after twenty years of operation.

Actual participation in the program will vary in accordance with the amount of benefits available to a family. A breakdown of Family Assistance eligibles by amount of benefits is shown below:

TABLE 5

Amount of annual family benefit	Number of persons (in thousands)	Amount of annual family benefit	Number of persons (in thousands)
0 to \$100.....	965.9	\$701 to \$800.....	707.1
\$101 to \$200.....	1,177.6	\$801 to \$901.....	721.5
\$201 to \$300.....	689.9	\$901 to \$1,000.....	1,077.0
\$301 to \$400.....	875.6	\$1,001 to \$1,499.....	3,310.1
\$401 to \$500.....	981.0	\$1,501 to \$1,999.....	3,228.4
\$501 to \$600.....	676.2	\$2,001 plus.....	3,350.3
\$601 to \$700.....	697.6		
		Total.....	¹ 18,458.2

¹ Does not include persons in families eligible only for State supplemental benefits.

A plausible relationship between benefits and participation is shown in the next table:

TABLE 6

Annual benefit	Participation rate (percent)	Annual benefit	Participation rate (percent)
\$0 to \$200-----	10	\$601 to \$800-----	70
\$201 to \$400-----	30	\$801 to \$1,000-----	90
\$401 to \$600-----	50	\$1,000 plus-----	95

Assuming less than 100 percent participation, the net additional federal welfare costs would be \$3.9 billion.

TABLE 7
[In billions]

Payments to Families-----	\$1.7
Fiscal Relief to States-----	.4
Adult Category-----	.9
Day Care and Training-----	.6
Administration-----	.4
Increased Costs Due to Food Stamp Check Off-----	-.1
Total-----	3.9

Estimates of actual recipients, assuming less than 100 percent participation are:

TABLE 8

COMPARISON OF PROJECTED RECIPIENTS UNDER THE FAMILY ASSISTANCE PLAN AND CURRENT LAW, 1972-76 (ASSUMES REDUCED FAP PARTICIPATION)¹

[In millions of persons]

	1972	1973	1974	1975	1976
Under family assistance plan:					
Persons in families receiving FAP only-----	8.0	7.7	6.8	5.9	5.0
Persons in families receiving FAP and State supplemental--	8.1	8.4	9.3	10.2	11.1
Adult category recipients-----	3.3	3.5	3.6	3.8	3.9
Total-----	19.4	19.6	19.7	19.9	20.0
Under current law:					
AFDC recipients-----	9.6	10.8	12.1	13.6	15.3
Adult category recipients-----	3.2	3.4	3.5	3.7	3.8
Total-----	12.8	14.2	15.6	17.3	19.1

¹ Assumes projected FAP participation rates at less than 100 percent and some impact of training programs.

B. FISCAL RELIEF FOR THE STATES

The program proposed by Senator Bennett and I would provide substantial and vitally needed relief to states now burdened by rapidly increasing welfare costs.

This relief is provided through two different approaches. First, the federal minimum payments in both the family and adult categories combined with federal sharing in supplementary programs will provide over \$400 million of immediate relief to state treasuries. Second, a "freeze" provision included in the Ribicoff-Bennett proposal will guarantee that state costs required under this program cannot exceed

90 percent (plus a cost of living factor) of welfare costs incurred by the state in calendar year 1971.

C. SUMMARY

The Beginning of a More Equitable, Efficient System

The welfare proposal outlined above represents a significant step toward a stronger, fairer and more efficient public assistance system.

The principles of the plan are directly related to solving the problems now facing welfare in the United States.

First, it provides more uniform national standards, including a federally supported minimum welfare benefit and national eligibility rules;

Second, it provides more efficient organization through simplified application and payment procedures and strengthened federal administration;

Third, it provides increased work incentives by including the "working poor" and expanding training and employment opportunities; and

Fourth, it provides increased assistance to presently eligible recipients now mired in poverty.

Let us be clear about the overall effects of this program. It will not reduce the number of eligible recipients. Nor will it reduce welfare expenditures. The needs of our poor, our sick, our elderly, and our children will not permit such reductions. Today, almost three out of every four poor children receive no benefit from federal welfare programs. Close to fifteen million poor Americans do not receive any assistance.

We must learn that we cannot save money by wasting lives.

The plan which Senator Bennett and I will introduce is far from perfect. It fails to include many of the steps I believe will be ultimately necessary for a strong welfare program.

Among other things, it does not cover single persons, or childless couples under 65. Eligibility for these people is a prerequisite for a truly universal assistance program. The basic federal payment of \$1,600 for a family of four is barely adequate. Federal sharing should be expanded to include state supplements to the "working poor".

However, it is fair to say that if the plan is not perfect, it is necessary.

Authorization of a program similar to that outlined above is a necessary first step in reforming American welfare.

V. OTHER COMMITTEE AMENDMENTS TO PRESENT WELFARE LAWS

In addition to the test program of Family Assistance, the committee has also recommended some amendments to present welfare laws. Several of these amendments are retrogressive and self-defeating; four of these are particularly important.

Use of Federal Funds to Support the Legal Process

One committee amendment prohibits the use of federal funds to pay directly or indirectly the salary of any individual who participates in legal actions designed to interpret or test federal legislation.

In a time when much emphasis is given to the desirability of settling our differences within established legal institutions, this provision seems particularly regressive and divisive.

No federal legislation should be immune from established and recognized judicial scrutiny. In our adversary system of justice, this scrutiny is best developed by legal actions originated by the parties in interest. Powerful corporations are fully entitled, in our system, to test laws in courts and deduct the costs of legal representation. In many cases, the only advocates for the poor are Community Legal Services personnel who, by a conscious policy decision of Congress, are often supported by federal funds. To deny these funds is to deny the right of effective advocacy to a large segment of our society.

American justice is based on the theory that all citizens are equal before the law. By denying effective representation in cases involving laws most directly affecting the immediate lifestyle of the poor, equality of rich and poor before the law becomes a myth.

Man In The House

The committee has resurrected a provision permitting states to deny AFDC benefits to children in families where a man may be occasionally present, even though he has no legal duty to support the child.

In 1968, the Supreme Court struck down a similar "man in the house" provision on the ground that an unrelated adult in the home has no legal obligation to support the child, and therefore, the child may be eligible for AFDC.

The committee's amendment set forth a long list of criteria by which a parental-type relationship could be established and the man be held responsible financially for the child.

In addition to the unrealistic burdens this would place on welfare administration, the provision would penalize the children for the conduct of the mother.

An unrelated man who visits a child's mother, no matter how regularly, cannot be relied upon to provide a meaningful parent-child relationship. If he does make financial contributions, these are counted in determining the family's benefits now.

Residence Requirements

Another committee amendment raises an additional issue recently ruled on by the Supreme Court.

In 1969, the Court declared durational residence requirements unconstitutional because they interfere with the right to travel.

The committee has sought to re-establish residence requirements, requiring that a recipient only receive payments equal to the lower benefit level from which he moved.

Whether this provision would correct the constitutional defect cannot be predicted, but it certainly would create inequities between residents of the same state. It would penalize new arrivals who were not previously on welfare but come to require it in the state to which they move, and would restrict the mobility of the poor who wish to seek better economic opportunity in a different state.

Definition of an Unemployed Parent

Present law authorizes a program, at state option, to support families in which the father is unemployed. This program is now operational in 22 states. In its regulations the Department of Health, Education, and Welfare has defined "unemployed" to mean less than 30 and in some cases 35 hours of work per week.

The committee amendment defining unemployment to mean less than 10 hours a week or 80 hours a month, is far too restrictive, and, in effect, defeats the purpose of the unemployed father program (AFDC-UP). It is hard to conceive that a man working 12 hours a week is fully employed. More to the point, it is unrealistic to expect that the wages of a few hours of work a week can adequately support a family. A more reasonable definition of employment will provide greater incentives for the partially employed to continue and improve their work skills.

VI. AID TO THE BLIND, AGED AND DISABLED

The Finance Committee has adopted minimum support levels for the 3 million recipients under the aged, blind and disabled program which are too low to support an adequate standard of living for an adult couple. The committee has adopted minimum payments of \$130 per individual and \$200 per couple per month. In addition, the committee has eliminated food stamps for these recipients. In comparison, the House bill passed payment levels of \$110 for an individual and \$220 for a couple, plus food stamps.

I propose setting minimum payments for needy adults at least at the level of \$130 for an individual and \$230 for a needy couple under the adult programs.

VII. CONCLUSION

Welfare reform is so urgent that the 91st Congress should not adjourn until the United States Senate has debated and voted on the merits of the issue.

Part Two—Trade

The trade features of this bill do not belong in the social security measure. They are so important they should be debated and voted upon separately and on their merits.

The portions of this bill containing the committee's foreign trade proposals bear vitally on the future direction of our own country's trade policies and those of our major trading partners. The proposed changes are of much greater potential importance to world stability than the particular situations they seek to remedy.

Fears have been raised abroad that because of its current economic difficulties, the United States will be tempted to pursue short-sighted protectionist policies with damaging and far reaching consequences. Some commentators have gone so far as to state that this legislation would spark a chain of reprisals and signal a return to mercantilism. There is an unfortunate tendency to paint the United States as the only villain here. But all industrialized nations do not have clean hands as far as their trade practices go.

By now it should be clear that trade problems will increasingly go to the root of our foreign relations with our European allies and Japan. With the United Kingdom negotiating its membership in the Common Market, we must begin planning now how we will get along with a trading bloc which will account for 40% of total world imports. Our trade policies will undoubtedly have a great influence on the political direction of Europe and Japan in the last quarter of the 20th Century.

Until now, our NATO and Asian policies and our conceptions of the future of Europe and Asia have been formed largely by geopolitical considerations. But with the growing prospects for political détente in Europe and the shifting of power in Asia, it will be the geoeconomic problems that will come to the fore. It is essential that we do not get on the wrong track at the outset. In an area where complexity is the rule, we have become bogged down in detail while paying insufficient attention to the larger issues involved.

Since the completion in 1967 of the Kennedy Round, world trade policy has been allowed to drift. While tariffs on certain items in world commerce still remain obstacles, it is the nontariff barriers to trade which are becoming major irritants in international commerce. The increasing use of new varieties of protectionism by ourselves and by other countries raises the real possibility that the great international conflicts of the 70's might well be trade wars.

In seeking to prevent damaging and senseless trade disputes, we seem to fashion our responses on a piecemeal basis. The brief hearings in the Senate on the legislation before us reflects this lack of depth. In addition, the Department and agencies in our government making and implementing our trade policies appear to operate without overall policy guidance and suffer from a lack of continuing high level attention. As economic issues are resolved on their own merits in isolation from our overall foreign policy objectives, they will continue to be subjected to special domestic pressures which too often prove irresistible because of their persistence, rather than their logic.

Our present decisionmaking processes in this area should be replaced by a more integrated framework, where policy can be more consciously arrived at. It follows that the Executive Branch of our government must be significantly strengthened to perform this task.

Given the enormity of the stakes here, we can no longer afford the luxury of thinking small when it comes to our foreign trade relations. If we and our trading partners devote our energies to planning reprisals rather than proposing initiatives, and to imposing new restrictions rather than seeking greater cooperation, it is clear that we will be working to the detriment of all. The chaos which must inevitably ensue from a failure to devise a workable set of international rules will poison foreign relations between nations and do harm to domestic economies.

The burden of creating a workable system of international trade, however, cannot be borne by America alone. Movement toward freer trade should not be a one-way street. The growing economic strength of the European Economic Community and Japan calls for corresponding give on their side and greater sensitivity on their part to our own problems. For example, the difficulties we face in negotiating a textile agreement with Japan is to some extent due to the barriers erected by the EEC countries against Japan's apparel exports. Also, the Common Agricultural Policy of the EEC affects American agricultural exports to Common Market countries, while the subsidization of EEC agricultural products inhibits American exports to other markets.

A willingness on the part of the EEC and Japan to join us in establishing guidelines and workable rules for international trade is essential. If nations are to stop trying to pass on the costs of their own

domestic problems to each other, they must first realize the mutuality of interest involved, and do more to harmonize and rationalize their trade relations.

For the United States this might mean seeking more flexibility in providing timely adjustment assistance for our own workers and industries. For European countries and Japan this could involve stricter adherence to agreed-upon groundrules.

Given the magnitude and potential significance of economic problems to world stability and progress in the years ahead we certainly need more complete and frank discussions of the basic issues involved. In the Senate we must have full and comprehensive hearings where we can hear from our best informed people and have all points of view presented. Only then can we begin to take responsible legislative action to resolve the paradoxes and baffling contradictions in our current trade policies.

I hope that in the next Congress we will have more opportunity to pay greater attention to these problems and gain new perspectives.

ABE RIBICOFF.

XIV. SEPARATE VIEWS OF MR. HARRIS

Introduction

The initial objectives of H.R. 17550 were to provide more adequate social security benefits and to make needed improvements in medicare, medicaid and maternal and child health programs.

The objective of H.R. 16311 was to effect urgently needed reform of a failing welfare system.

These objectives are highly laudable. However, by the addition of unrelated matters, unwise amendments and weak substitutions for some provisions, these original objectives have been made hostage to other, less noble, aims.

The Trade Act of 1970 was added as an amendment to H.R. 17550.

Various amendments to the present welfare laws were agreed to which can only be characterized as regressive and punitive.

An amendment to establish a Federal Child Care Corporation, which would represent a substantial and objectionable change in child care programs, was adopted.

I, therefore, voted against reporting the bill. My reasons for doing so are here set forth in detail.

Social Security

A. INCREASE IN BENEFITS AND MINIMUMS

The committee made several greatly needed improvements in the social security provisions of H.R. 17550.

The 5 percent increase in benefits, adopted by the House, was stepped up to a 10 percent increase. The committee also rightly voted to provide a \$100 minimum social security benefit level.

With these increases, H.R. 17550 became an acceptable advance this year toward fairness in our social security program.

B. WORKMEN'S COMPENSATION OFFSET

The committee made certain other changes in the House bill provisions regarding social security which were undesirable.

The provision in the House bill, amending present law which requires social security disability benefits to be reduced when workmen's compensation is also payable and when the combined payments exceed 80 percent of average current earnings before disablement, was stricken.

The House bill called for a reduction in benefits by the amount by which the combined payments under both programs exceed 100 percent of average current earnings before disability. This provision should be restored.

C. FINANCING

When the committee finished its work, it had voted approximately \$10 billion in additional benefits. It then turned to financing.

I believe the committee was mistaken in not properly taking into account the presently regressive nature of the social security tax system and in not fully considering the economic impact of the financing arrangements which it approved.

The social security tax system is not as nearly based upon ability to pay as is the Federal income tax. There is an upward limit—presently \$7,800, and \$9,000 under the committee bill—on the amount of salary which is taxed. The tax is in a flat rate basis; it is not graduated.

I believe that the payroll tax under social security has reached the saturation point. I, therefore, supported an effort to finance a portion of benefits from general revenue. This effort failed.

Alternatively, I offered a financing plan which would make the social security tax system more progressive by raising the wage base to \$12,000 in 1971. This allows actuarial soundness with less of an increase in the tax rate over a period of years. The following table shows the financing plan which I offered and which was rejected by the committee. As indicated, in addition to providing actuarial soundness over the long term in each of the funds involved—OASDI, health insurance and the new catastrophic health insurance—the plan which I offered would avoid a cash deficit in any year in any of the funds.

[In percent]

	OASDI	HI	CI	Total
1971.....	4.1	0.7		4.8
1972-74.....	4.1	.8	0.3	5.2
1975-79.....	5.0	.9	.35	6.25
1980-84.....	5.5	1.0	.35	6.85
1985 plus.....	5.85	1.0	.4	7.25
	-.15	-.06	+.02	

Note: The excesses of income over outgo resulting from this schedule follow:

[In millions of dollars]

	OASDI	HI	CI
Fiscal year 1972.....	1,079	1,044	589
Calendar year 1971.....	97	560	
Calendar year 1972.....	1,519	1,303	565
Calendar year 1973.....	2,843	851	403

The financing plan which I offered would also provide an additional and very important economic impact. It would postpone an increase in the tax rate from 4.8 to 5.2, which is otherwise scheduled to go into effect in January 1971 under present law. Unless this rate increase is postponed, it will have a seriously dampening effect on consumer demand at a time when the economy is much too sluggish and unemployment intolerably high. Stimulation of consumer demand through postponement of the presently scheduled tax rate increase and through increased benefits would not be inflationary by serving to cause expanded production volume, allowing some reduction in unit costs.

The revised manner in which Federal budgets are now made up and presented, taking into account income and expenditures from social security and other trust funds, more clearly points up the fiscal impact of decisions concerning social security benefits and rates.

In addition to the right of social security beneficiaries to more adequate benefits, the payment of increased benefits will provide a much-needed increase in consumer demand, aiding economic recovery. This fiscal impact should not be offset by immediate rate increases, primarily the way in which the automatic adjustment of the benefits vent an annual deficit in the various funds or to provide general actuarial soundness.

D. COST-OF-LIVING INCREASE

The committee worked long and hard on the problem of how to insure that the purchasing power of social security benefits is maintained. On the whole the committee acted wisely in this regard; however, I disagree with some aspects of the automatic adjustment provisions—primarily the way in which the automatic adjustment of the benefits is financed.

The committee made some major changes in the automatic adjustment provisions that were proposed by the administration and passed by the House of Representatives. Many of the changes are reasonable, but some aspects of the provisions agreed to by the committee should be changed if they are to be fully acceptable and are to operate smoothly.

There are two major difficulties with the committee provisions concerning automatic adjustment of social security benefits and automatic financing.

First, the committee bill would require the Secretary of Health, Education, and Welfare to promulgate increases in both social security tax rates and the earnings base in order to finance the automatic increases in benefits, even though such increases in social security taxes would be unnecessary and would greatly over-finance the program. Under the committee bill, whenever an automatic cost-of-living increase in benefits occurs, the Secretary would be required to increase social security taxes. Such increases in taxes would not be necessary because a large part of the cost of the automatic benefit increase would be met from rising earnings levels without increasing either the tax rate or the earnings base.

Second, the provision for automatic increases in the earnings base as wages rise, proposed by the administration and passed by the House, does not constitute a discretionary delegation to the executive branch. The increases would be automatic and the determination of the amount would be routine on the basis of social security wage record statistics.

Under the committee revision, on the other hand, it would be necessary for the Secretary of Health, Education, and Welfare, as a part of the automatic provisions, to determine both the short-range and long-range "cost" of each automatic benefit increase, and we would in effect be turning over to the Secretary of Health, Education, and Welfare the tax-setting function of the Congress.

The provision approved by the House would merely carry out automatically the policy which the Congress has been following on an *ad hoc* basis since 1950—that is, periodically increasing the social security

earnings base so as to cover the same proportion of payroll as had been covered earlier, when wage levels were lower. As wages have risen, the \$3,600 base that became effective in 1951 has been changed by the Congress, in steps, to \$7,800—as it would have been under the automatic provisions. It is important to increase the base to keep up to date with rising wages, not only from the standpoint of the income of the program but to prevent a deterioration in the coverage of the program. For example, a job which paid \$3,600 in 1950 pays around \$9,000 today. If the base had not been increased over the years the benefits payable to a man in such a job would provide a much smaller proportion of wage replacement than they were originally intended to, and there would have been a major deterioration in the protection afforded by the program. If the base is kept up to date with rising wage levels, there will be little if any need for an increase in the tax rate to cover the cost of the automatic cost-of-living increase.

The House provisions in this regard are, therefore, preferable to the provisions adopted by the Senate, and they should be restored.

The House bill requires the Secretary of Health, Education, and Welfare to increase social security benefits any January, commencing January 1973, if he finds that the cost of living has increased by 3 percent or more between the last July-to-September calendar quarter preceding a secretarially determined benefit increase and the most recent July-to-September quarter. The automatic increases would be in addition to any increases which might be passed by Congress. The taxable wage base would increase automatically every 2 years based on increases in the average taxable wages after 1971.

Medicare and Medicaid

A. HEALTH MAINTENANCE ORGANIZATIONS

Medical costs have risen enormously. There are many causes for this. One cause is the greatly increased demand for medical services without a concurrently increased supply in personnel and facilities.

It is imperative that there be a massive increase in medical and paramedical personnel and in medical facilities. The shortages are already acute, and they are growing alarmingly.

It is also vital that there be much better use of existing personnel and facilities. Toward that end, the committee approved the health maintenance organization concept contained in H.R. 17550. Under this provision, medical payments can be made to physicians on a per capita basis, rather than on a fee-for-service basis only.

This provision is an important step forward toward encouraging prepayment for group medical practice and toward greater emphasis on preventative medicine.

B. PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The committee adopted a proposal to establish professional standards review organizations at local and State levels throughout the country to review such functions as examination of patient and practitioner profiles; independent medical audits; on-site audits; and the development and application of norms of care and treatment.

The Secretary of Health, Education, and Welfare would be required

to enter into agreements with qualified professional standards review organizations, principally local medical societies, to review the totality of care rendered or ordered by physicians for medicare and medicaid patients. Where medical societies are unable or unwilling to undertake the responsibility, the Secretary could contract with States or local health departments or other suitable organizations.

This provision has a laudable purpose: to insure quality care and to hold down unnecessary costs.

However, the proposal contains many unknown and unpredictable factors. Further, there are serious objections that it grants organized medicine too much control over utilization of facilities and payments of claims.

The proposal should be tested before Congress puts it into effect on a total basis as the committee bill would do. I am not satisfied that this proposal will result in the savings which have been claimed by its proponents, nor am I satisfied that the review procedure is the best and most workable which can be devised.

The House provisions on peer review should be strengthened, and the Senate committee provisions should be stricken.

C. STATE MAINTENANCE OF EFFORT

Under present law States are required to maintain their present financial efforts in support of medicaid and are required to build toward comprehensive medicaid programs by 1977.

The State of Missouri asked the committee to pass legislation giving it a special one-time exemption from the maintenance of effort requirement. The committee could have granted this special request, based upon unique circumstances, without upsetting the present law.

But the committee went far beyond the Missouri request and repealed the entire section 1902(d) of the present law, under which States are required to maintain their financial efforts under medicaid. The House of Representatives had previously stricken section 1903(e) which requires States to enact comprehensive medicaid programs by 1977.

The repeal of both these sections is most unfortunate. The poor people covered by medicaid are entitled to better medical attention and care—not less. Their needs should not be ignored in order to slow the rising costs of this program and medical care generally. Section 1902(d) and section 1903(e) should be restored in the bill.

D. PHYSICAL THERAPY

The House bill provides for reimbursement of up to \$100 of the cost of physical therapy on an outpatient basis in the office of an independent practitioner under part B of medicare. This provision was rejected by the Senate committee.

A great many beneficiaries need the services of a physical therapist, and these services can often best be performed in the office of the therapist. The limited reimbursement that the House approved, which in effect puts it on a trial basis, should be reinstated in the bill.

E. BLOOD REPLACEMENT

The committee rejected a proposal to eliminate the requirement in the present law for a medicare patient to pay for or replace the first

three pints of blood used by such patient. This requirement seems unreasonable. It places an undue burden on medicare patients, and it should be eliminated.

F. MEDICARE PREMIUM INCREASES

The premium for part B, supplementary medical insurance, under medicare has increased by more than 80 percent in the last 4 years. Originally the premium was \$3 a month per person. It was increased from \$4 to \$5.30 on July 1, 1970. For those living on social security, this increase is almost prohibitive and it should be eliminated if the aim of medicare is to be realized.

Welfare Reform

A. NEED FOR REFORM

During the past few years, the need for reform of our welfare system has assumed crisis proportions. Three parallel developments have dramatized the urgency: sharply increasing welfare rolls, growing recognition of the inefficiency and failures of the system itself, and ever more crippling fiscal burdens on States and localities.

Neither the poor—a group that is widening every day in the current economic climate—the Nation's stability, nor any pretense to sound social policy can wait longer for a rational income maintenance system.

This case has been made so often and so convincingly by mayors, Governors, welfare administrators, recipients, social scientists, and political figures of every persuasion that there is no need for it being made again.

Toward this end, I introduced with seven other Senators the National Basic Income and Incentive Act, S. 3433. This bill calls for the federalization of the presently outdated, unworking, and inhumane welfare system, replacing it with a Federal income maintenance system. It represents a significant departure from our present thinking about welfare and represents true reform.

I had hoped that improvements in H.R. 16311 could be made that would move the family assistance plan closer to the concepts of the National Basic Income and Incentive Act and real reform. Unfortunately, the committee moved in the opposite direction and was willing to approve only a test of various pilot reform programs.

Passage of a test proposal alone will surely delay congressional consideration of real reform for at least 3 years. I do not believe that the Nation can wait.

There is good reason to predict that the number of families and individuals requiring financial aid will continue to increase, that State and local funds crucially needed for programs to reduce dependency will be drained by the demands of public assistance, that the inequities of the present system will continue to demean recipients so as to destroy their incentive, and that the entire Nation will suffer from a welfare system that must be revised.

B. REQUIREMENTS FOR REAL REFORM

Perhaps if the administration had been willing to make progressive changes in the House-passed version of the family assistance plan, rather than regressive changes during the consideration of the bill by the committee, something more substantial than a test would have been reported by the committee. Elimination of mandatory coverage of families headed by an unemployed father (AFDC-UP) and elimination of the requirement that States maintain current benefit levels for families with income, provisions that were in the President's original welfare reform proposal, weakened support for the bill in the committee by those of us who were advocating more meaningful reform of our welfare system.

A failure to recognize the importance of requiring the minimum or prevailing wage, whichever is higher, also weakened support for the bill.

While I do not believe that the administration has gone as far as it should, I am pleased that it has now agreed to some of the changes in the family assistance plan which Senator McCarthy, Senator Ribicoff and I and others advocated. The changes the administration has now approved are embodied in the amendments offered by Senator Ribicoff and Senator Bennett.

I believe that additional improvements can and should be made.

Recognizing that Congress is not willing to completely federalize the welfare system at this time, a goal should nevertheless be established for moving within a time certain toward a welfare system that is federally financed and administered. Included within the goal should be a commitment to move the level of payment to an adequate income. Our goal is to assist people in getting out of poverty, but a floor at a low level, instead of raising families out of poverty, means only continued poverty with little prospects for breaking out.

Any system of reform should also require that the prevailing or minimum wage, whichever is higher, should be paid for those who are forced to take a job. Otherwise, a captive work force with insufficient standard of wage to be paid will be available to employers, and the effect will be to keep wages so low that millions will remain in poverty though working full time.

Any version of the family assistance plan that is adopted by the Senate should not require mothers with school-age children to work. Mothers should have some control over whether day care centers are good enough for their children.

Furthermore, a provision to provide for cost-of-living increases in payments to recipients should be adopted. We have recognized this principle with regard to those who are receiving social security payments, and the same arguments can be made in support of providing cost-of-living increases for those on public assistance.

Any system of welfare reform should also fully protect the rights of present recipients and of applicants to insure that the new law does not create different classes of citizens.

A national system of income maintenance, recognizing the needs of the working poor, setting uniform national minimums of assistance and removing present barriers to incentive and initiative is desperately needed.

These principles can and must be embodied in real welfare reform, together with programs which assure that, through expanded public service jobs and otherwise, people have a real chance to get a job.

C. REGRESSIVE AMENDMENTS

Unfortunately, the committee adopted a number of amendments to our present system that are regressive.

The most disappointing action of the committee was the barring of legal service lawyers from representing welfare recipients. Much of the work of these lawyers in the past few years has been to secure benefits guaranteed by law, but not received by poor people due to illegal regulations and administrative practice.

During the past 3 years welfare recipients and lawyers associated with federally funded legal service programs have compiled a remarkable record of service to poor people. Significant court decisions have begun to nudge the welfare system toward a more equitable and enlightened program. Cruel and demeaning regulations, irrelevant to the purposes of the Social Security Act, have been overturned in the courts.

The Finance Committee has proposed that this record of progress be nullified. This restrictive amendment, adopted by the committee, should be defeated.

Other undesirable amendments were adopted by the committee.

The committee would make the leaving of a family and moving across State lines a Federal misdemeanor. This is an unwarranted extension of Federal police power into intimate aspects of family life and, in view of the State laws now regulating this subject, would prove to be unworkable.

The action taken by the committee in instituting a 1-year residency requirement for people in need of assistance, was likewise regrettable. The committee provision is in conflict with the Supreme Court's opinion in *Shapiro v. Thompson*, 394 U.S. 618, in which it was held that citizens have a constitutional right to travel throughout the States and that welfare eligibility regulations should not impede that right. The committee position would restrict the right to travel precisely in the manner prohibited by the Court.

The committee was also mistaken, in my opinion, in resurrecting the onerous man-in-the-house rule. This rule, knocked down by court decision, would base eligibility not on actual resources but on imagined income from people not legally obligated to support the children involved.

Provisions were also adopted that require the return of amounts paid to welfare recipients who do not prevail at hearings; that eliminate progress made in the declaration system; that cut back on the Federal assistance now available to families with a father in the home; and that provide eligibility requirements wholly unrelated to the need of poor children.

Adoption of these provisions represents a step backward in our efforts to devise a more workable and humane system of welfare—an entrenchment of old myths about welfare and welfare recipients that should have been cast aside years ago.

D. AID TO AGED, BLIND, AND DISABLED

The committee made substantial changes in the House bill with regard to benefits for the aged, blind and disabled. The House bill provided for a minimum of \$110 a month for single individuals and \$220 for couples. The committee approved \$130 for single individuals and \$200 for couples, cashing out food stamps.

Taking into consideration the fact that an increase in social security benefits reduces Federal and State expenditures for the aged, blind and disabled—and considering their great and growing needs—the Senate should provide for a minimum of at least \$130 for single individuals and \$230 for couples, not cashing out food stamps for these individuals.

E. CATASTROPHIC HEALTH INSURANCE PLAN

A critical problem has arisen because of the rapidly increasing costs of medical care that have left 90 percent of all Americans medically indigent. No one questions the need to provide a better means for the average American citizen to finance his health care.

While I agree with the objectives of the catastrophic health insurance plan, I voted against attaching the plan to H.R. 17550. When the plan was presented to the committee for consideration, H.R. 17550 was already heavily loaded with extra, and in some instances non-germane amendments, and it did not seem appropriate to add to the bill such a massive new health program.

The problem which the catastrophic health insurance plan seeks to meet is pressing and must be solved. But it does seem that the problem could be more appropriately solved in a broader context of national health insurance and by considering the whole matter in a more deliberate and careful fashion.

There is little chance that any such new program as this can be adopted this late in the postelection session in any event, and the attachment of the measure to the already overburdened social security bill may tend to defeat the bill to which it is attached.

The chairman is to be congratulated for offering a solution to the crisis and for urging prompt action. With his interest and his strong desire to see legislation enacted, the committee should give this matter prompt attention at the beginning of the next session. At that time there will be full opportunity to give attention to the financing of catastrophic illness costs and to the financing of all health care, including the need for an urgent and massive increase in medical and paramedical personnel and facilities.

F. FEDERAL CHILD CARE CORPORATION

There is a great shortage of quality child care facilities and services. We need to do more to promote the development of increased facilities and services. But the establishment of a Federal Corporation is not the way to achieve the needed results.

The Corporation under the committee bill would have the responsibility for arranging for child care services in the various communities of each State. Existing public, private nonprofit, and proprietary facilities would be contracted with by the Corporation to serve as child

care providers. Pursuant to the terms of the provision adopted by the committee, the Corporation could provide child care services in its own facilities.

A fee would be charged by the Corporation for its services, to be paid either by the consumer of services or by a public agency.

I have grave concern about this approach to quality child care. Child care is a proper subject for local community concern and planning. The Federal Child Care Corporation approaches child care needs from the top.

Parental involvement is crucial in early childhood programs. If the parent is actively involved, there will be a positive overlap in the home and the community. I feel that this would be unlikely under the operation of the Federal Child Care Corporation.

I question whether the standards set out in the bill are high enough. These standards, coupled with the striking down of local and State regulations, could lead to purely custodial child care.

I am also concerned that with a growing number of commercial franchisers entering the day care field, a great tendency would exist for the Federal Child Care Corporation to contract with these franchise operations. If so, this could lead to a depersonalization of child care services and eliminate or reduce community control and parental involvement—the hallmarks of good child care.

Child care has not received proper attention from the Congress. It should be a matter of top priority for the next session of the Congress. We must soon enact major legislation which will provide quality child care on a universal basis, not stigmatized by welfare alone, not controlled by private business, but controlled by the local community and with full involvement of the parents.

The provision in the present bill does not meet these crucial tests.

Trade Act of 1970

I strongly opposed the attachment of the Trade Act of 1970, H.R. 18970, to the social security amendments. Not only did I object to the Trade Act on its merits, but I also thought it unfortunate to reduce the chances of passing much-needed welfare reform and increases in social security by attaching nongermane legislation.

I have general objections to the overall thrust of the Trade Act, as well as specific objections to its provisions. First, I will set forth my general reservations about the act.

A. BALANCE OF TRADE

It is presently estimated that in 1970 we will have a healthy surplus of over \$3 billion in our trade balance. Last year, the surplus was under \$1 billion. In other words, this year our exports have been growing considerably more rapidly than imports.

The argument that U.S. industry is becoming increasingly non-competitive, which is often made in support of the Trade Act of 1970, is invalidated by these figures. This would therefore seem to be an especially poor time to risk loss of export markets by curtailing imports.

Another effect of quotas which would be imposed under this bill

would be the retardation of economic growth in developing nations. This is at odds with our larger foreign policy to encourage the strength and growth of these less developed countries.

B. COST TO CONSUMERS

Recently, Federal Reserve Board Governor, Andrew Brimmer, said that the textile and shoe quotas in this bill would cost the consumer an extra \$3.7 billion, and that these costs would be borne disproportionately by the poor because they must spend a larger share of their income on shoes and clothing than do more affluent citizens. Whatever the merits of the industries' case—and I want to return to this—it would seem that the consumer would have to pay a very heavy price indeed for these quotas.

These costs could multiply if other consumer items were subjected to quotas under the liberalized escape clause.

C. IMPACT ON INFLATION

Much attention has rightly been focused on the economy in recent weeks. The inflation alert, the President's speech to the NAM—all focus on the real danger of inflation. Mr. Arthur Burns, in speaking on measures to combat inflation last week, suggested the relaxation of existing quotas on imports. This comes at a time when new inflationary quotas would be imposed by the trade bill. We obviously cannot have it both ways. We must draw the line and choose between control of inflation and protectionism.

Another voice raised in opposition to the import restrictions of the bill is that of the Chamber of Commerce of the United States. The Chamber has urged that a more constructive course on trade legislation be charted in the next session of Congress.

D. DANGER OF RETALIATION

I have also noted in the press an increasing number of statements made by officials of foreign governments, including some of our best customers—Canada, Germany, Latin America, Britain, and Mexico, to name a few—concerning the possible adverse consequences of the enactment of the trade bill. One can, of course, dismiss these statements as bluffing, on the assumption that other countries either could not or would not dare to curtail our exports. But is this assumption necessarily correct? In many instances, other countries would be able to obtain the same goods of comparable quality from alternative sources. Moreover, other countries watch their trade balance with the United States very carefully and would be very prone to reduce their purchases from us if we were to restrict their exports to this country. Finally, I think the element of national pride would be at work here. If they feel—as they seem to—that the textile and shoe quotas, for example, are unjustified, then they will naturally want to strike back. The risk of an old-fashioned trade war is, in my judgment, severe. If that happens, no State will be immune from its effects. In testimony before the Finance Committee, the National Chamber attributed 4 million American jobs to total United States exports. The wheat farmers of western Oklahoma have made Oklahoma the No. 3 wheat exporting

State in the Nation. A generation of eastern Oklahomans have pinned high hopes on the Arkansas River Basin project which the late Senator Kerr spent so many years helping to develop into a navigable access to world commerce. All of these stand in real jeopardy in the face of restrictive trade policies.

E. RENEWAL OF TEXTILE NEGOTIATIONS

The trade bill was approved by the House Ways and Means Committee after the Secretary of Commerce announced that the United States-Japanese textile negotiations had broken down and that the administration therefore reluctantly supported legislative quotas. In the past weeks, however, these negotiations have been resumed. There is admittedly no assurance that these negotiations will be successful either in the short or long run. But the fact of their resumption is surely significant and affords further reason for pause in considering the trade bill. The Japanese Government feels an early voluntary agreement is desirable because if there is no agreement and no legislation is passed this year, Congress may pass even more restrictive legislation next year.

F. TEXTILE AND SHOE QUOTA

To the best of my knowledge, there has been no objective determination that imports are causing or threatening serious injury to the domestic textile industry. Of course, the industry itself makes vehement allegations of jobs eliminated and production lost because of imports. But has any reasonable independent body like the United States Tariff Commission ever come to that conclusion? I would emphasize that I am not asserting that there are no parts of the textile industry that may be injured by imports. I am rather asking for evidence that there is a serious import-related problem affecting the entire industry.

In the face of such evidence, action is certainly required. Full use of present legal remedies should be made. Stronger and more aggressive diplomatic initiatives by the administration could result in voluntary limitations on specified imports.

However, statistics from the American Textile Manufacturers Institute reflect that annual textile exports have expanded by \$200 million over the past 12 years. More U.S. employees are engaged in making textile mill products now than in any year except 1968. The number of employees engaged in apparel manufacturing is at an all time high. Net sales, both in textiles and apparel, are the highest ever, nearly doubling 1960 figures. Taken as a whole, these facts do not support allegations of a severely depressed industry, requiring emergency legislation. In the absence of impartial evidence of harm from imports, I must question the need for, and the wisdom of, unilateral textile quotas, especially in view of their cost to the consumer and the possibility that the United States-Japanese negotiations may be successful.

As for shoes, a task force of the administration itself concluded just several months ago that there is no justification for quotas. Nevertheless, the President has asked the Tariff Commission to determine whether imports are causing or threatening serious injury to the do-

mestic industry. This is the proper way in my judgment to develop a sound basis for informed and intelligent action concerning imports.

G. ESCAPE CLAUSE PROVISIONS

Another provision of the trade bill that is very troublesome is the amended escape clause, which has traditionally authorized the President to impose higher tariffs or quotas on imports found to be injuring a domestic industry. The following aspects of the new escape clause are open to serious question.

First, under the trade bill the Tariff Commission would have to determine whether imports are a "substantial" cause of serious injury. Instead of "substantial," present law reads "major" and the administration's bill would have substituted "primary." These may sound like semantic quibbles, but the difference between "primary" and "substantial" could spell the difference between a reasonable and a promiscuous use of the escape clause.

Second, the bill resurrects the concept of geographic segmentation, which permits the Tariff Commission to carve up an industry and artificially select just that portion that will maximize the chance of an affirmative finding of injury. The Tariff Commission would be given the license to do so even though it made no economic sense and even though the companies and workers concerned were in fact able to make a successful adjustment to whatever import problem may have existed. One of the important features of the Trade Expansion Act of 1962 was its repeal of the geographic segmentation provision. Its resurrection is a major threat to an enlightened foreign trade policy.

H. FOREIGN IMPORT RESTRICTIONS

The committee has gone even further than the House bill in making section 252 of the Trade Expansion Act of 1962 a protectionist device. At the present time, section 252 authorizes—but does not require—the President to impose new restrictions on imports from countries that are illegally or unreasonably restricting our exports. The key issue, of course, is who determines whether a foreign import restriction is illegal or unreasonable. The right of any member of the GATT to impose new restrictions is severely restricted by that agreement—as it should be if any order in international trade is to be preserved.

Under the committee's bill, the Secretary of Commerce would determine if a foreign import restriction is illegal or unreasonable. If he made an affirmative finding, the President would be authorized to work out a solution with the foreign country concerned. If he could not in 3 months, then he would have to take retaliatory action. This is—pure and simple—another radical violation of the GATT and another example of a blind attitude that somehow the United States can flout the rules of the game and get away with it.

I. STATUS OF GATT

The committee struck the new separate authorization for appropriations to finance our annual contribution to the GATT. This will probably not seriously jeopardize future appropriations, since there is a

general authorization available in the organic legislation of the Department of State. But it is obviously a vote of no confidence in the only international organization that offers any hope of maintaining and strengthening a fair world trading system.

The committee struck the provision on the ground that it would give "statutory recognition of the GATT, which has never been submitted to the Congress for approval." The fact is that the GATT is a valid executive agreement, concluded pursuant to the authority of section 350 of the Tariff Act of 1930. As a statutory executive agreement, it need not, of course, be submitted to the Congress for approval. This question dealt with extensively in a 1956 memorandum of the Legal Adviser of the State Department to the then chairman of the Ways and Means Committee (see H. Rept. 2007, 84th Cong., second sess., 113-131 (1956)).

J. AMERICAN SELLING PRICE

The committee struck the provision in the House version that would have provided for the elimination of the American selling price (ASP) system of customs valuation as it relates to benzenoid chemicals. This system has been found to be without justification by both the Johnson and Nixon administrations, and the United States is pledged to seeking its abolition in one of the agreements concluded in the Kennedy Round. If this system is not to be abolished, there is little, if any, hope of making further progress for some years to come in the field of nontariff barriers. Once again, the blind approach is at work: Let other countries remove their nontariff barriers, while we stand pat.

K. FAILURE TO TAKE POSITIVE ACTION

Beyond the positive and enormous harm done by the bill, it also fails to seize critical opportunities to move ahead:

(1) *Tariff-Reducing Authority*.—The House bill by clear legislative history and the committee's bill by express statutory language would give the President new tariff reducing authority only for the purpose of granting compensatory tariff concessions when we increase import restrictions under the escape clause or by some other means. In other words, this is an authority that at best permits us to stand in the same place, but envisages no further net reduction in tariffs.

The Kennedy Round was concluded in 1967 and the last tariff reductions agreed to will take place on January 1, 1972. Isn't it time to give the President the authority to start moving again in lowering trade barriers? How can the momentum of trade liberalization be maintained if the past leader of that effort is powerless? And especially in the trade field, the absence of progress only invites retrogression.

(2) *Non-Tariff Barriers*.—Even with the provision authorizing the elimination of ASP, the House bill failed to provide for negotiations on nontariff barriers, though everyone agrees that this is the single most serious problem in the trade field. As it stands now, the President must act at his peril if he acts at all. On the one hand, he can negotiate on nontariff barriers without any prior congressional approval and simply hope that the Congress will provide the necessary implementing legislation after the fact. The handling of ASP, of course, affords

little encouragement. On the other hand, the President can request specific authority before beginning any particular negotiations on non-tariff barriers. The Congress may then so circumscribe his authority as to render it valueless or give him none at all, since it has not yet seen what reciprocal advantages it might afford the United States.

The only way I can see out of this dilemma is to have the Congress give the President, perhaps in the form of a resolution, the "license" to negotiate, while reserving all of its authority to pass upon any necessary implementing legislation. This would at least give the President the encouragement he does not now have to tackle nontariff barriers and attempt to commence an international negotiation on the subject.

1. Conclusion

The total effect of the trade bill is, in my judgment, antagonistic to constructive ways of dealing with the current problems in international trade. It assumes that the United States can take unjustified and indeed illegal actions and somehow get away with them, without provoking retaliation or undermining the world trading system. This seems to me to be a hopelessly naive and false assumption. It is my opinion that if the Senate will seriously consider how harmful the present trade bill is and how great is the need for a constructive trade bill, then we may still have the time to avert the appalling consequences of a return to protectionism both in this country and throughout the world.

I re-emphasize that I am concerned about the allegations of serious injury resulting from imports being voiced by the textile and other industries. Present law provides for remedies in such cases. Full use of present provisions should be employed where need is indicated. Adjustment assistance should be used to ease the conversion of industries and jobs in cases requiring such relief. Diplomatic negotiations should be pressed. Lastly, the Congress should carefully and deliberately consider additional thoughtful trade legislation, which is in keeping with our past policies of free trade and which does not violate international agreements which we have previously made.

I attempted twice in the committee to have the trade bill stricken from the social security bill. I will renew this effort on the floor of the Senate. Should this motion fail, I intend to offer a series of amendments to improve the Trade Act.

Conclusion

All of the legislative proposals included in H.R. 17550 are in need of thoughtful legislative consideration. My opposition to specific proposals in the bill by no means indicated a lack of concern for responsible action on the problems raised thereby. But, it is too late in this post-election Congress to hope for any fruitful action on so many diverse issues placed under the same umbrella.

Therefore it is imperative, as I have set forth in these separate views, that the Senate in the remaining days devote its time to improving our social security and related programs and to meaningful reform of our failing welfare system. The other matters can and should be set aside for consideration by the next Congress.

FRED R. HARRIS.

XV. ADDITIONAL VIEWS OF MR. WILLIAMS OF DELAWARE AND MR. CURTIS

We believe that there should be some social security legislation at this time. We favor an increase in the benefits, including special consideration to those social security recipients who are receiving the smaller amounts.

There is also a need for certain corrective amendments in reference to medicare and medicaid. There are some changes that need to be made that will be beneficial to the patients involved and also to the local hospital boards and the States. There are some changes in reference to welfare that are urgently needed by local governments and States in order to properly administer the program.

H.R. 17550 and the amendments recommended by the Senate Committee on Finance do some of these things and meet some urgent needs. However, the bill as it comes from the Committee on Finance goes too far. It involves many costly features which will eventually lead to a tax burden greater than should be imposed upon the employees, employers, and self-employed persons, and therefore we cannot support it in its present form.

JOHN J. WILLIAMS.
CARL T. CURTIS.

XVI. SEPARATE VIEWS OF MR. MILLER

I deeply regret that this bill, with many good features, has become so overloaded that I cannot in good conscience support it as it now stands.

First, trade legislation, which could hardly be considered germane to the subject of social security, was tacked onto the bill as an amendment after only brief hearings. Although the amendment represents some degree of improvement over the House-passed trade bill, it goes too far. For example, by a vote of 9-8, the committee rejected my amendment to delete the quota provisions relating to shoes. And this notwithstanding the fact that, as Stanley Nehmer, Deputy Assistant Secretary of Commerce for Resources, pointed out (See Congressional Record for December 3, page S19294) the difference in size of the problems of textiles (30,000 firms) and shoes (675 firms) is so different that they do, in fact, take on a difference in kind. He noted that the loss of 100,000 jobs in the textile industry from January through September of this year equals 50 percent of the total employment in the non-rubber footwear industry.

In any event, trade legislation of the magnitude of the present amendment should stand on its own two feet rather than ride piggy-back on a legislative vehicle whose importance might transcend the undesirable features of trade proposals.

Second, the increase in the minimum social security benefits from the present \$64 per month to \$100 per month at an annual cost of \$1.5 billion to the social security trust fund is inequitable. Acting impulsively on the simplistic plea that "no one can live on sixty four dollars a month", the Senate last December adopted such an amendment to the Tax Reform Act of 1969. This was quickly disposed of by the House Conferees during the conference on the bill who noted that a large number of the recipients of the social security minimum already receive benefits from one or two other pensions—civil service retirement, state and local retirement, or private corporation retirement; and that state old age assistance payments prevent anyone from having to live on \$64 per month. Instead of applying the proposed 10 percent increase in social security benefits across the boards to include the present minimum, which would mean an increase from \$64 to \$70.40 per month, the bill provides an increase in the minimum to \$100—regardless of need—at a cost to the taxpayers of \$1.5 billion per year.

Worse yet, this \$1.5 billion plus also the amount needed to cover a 10 percent increase in the minimum would be paid for by those paying social security taxes into the social security trust fund. Inasmuch as those who receive the "minimum" have not paid taxes sufficient to cover their benefits, the load is thrown on those who are

already paying taxes sufficient to cover their benefits. In short, most of the minimum social security benefits provided by the bill represents welfare—not tax paid insurance. It should, therefore, be paid out of the general fund of the Treasury. Moreover, as welfare, the payments should be made on the basis of need, taking into account other resources of the recipient.

The bill makes no attempt to order our priorities. Instead, it contains all major social security proposals—the 10 percent increase, the increase to \$100 in the minimum, and coverage of catastrophic illness and disease. It would seem that the single most urgent action to be taken—one that should have been taken long ago, before medicare and medicaid—is coverage of catastrophic illness and disease. Also, it is only fair to bring social security benefits into line with increases in the cost of living which have occurred since benefits were last increased. It would appear that this would fall somewhere between the 5 percent increase provided by the House and the 10 percent increase provided by the Senate Finance Committee. The increase in the “minimum”—particularly the \$1.5 billion needed to go beyond a cost-of-living increase—is inequitable and excessive.

Those who would be paying the bill should know what lies in store for them. The tax base would be raised from \$7,800 to \$9,000, with the following rate changes:

TAX RATES ON BOTH EMPLOYER AND EMPLOYEE

[In percent]

Year	Under present law	Under the bill	Under the bill without \$100 minimum
1970	4.8		
1971	5.2	5.2	5.1
1972	5.2	5.5	5.4
1973-74	5.65	5.6	5.5
1975	5.65	6.35	6.35
1976-79	5.7	6.35	6.35
1980-85	5.8	7.0	7.0

TAX RATES ON SELF-EMPLOYED PERSONS

1970	6.9		
1971	7.5	7.4	7.3
1972	7.5	7.7	7.6
1973-74	7.65	7.8	7.7
1975	7.65	18.35	18.35
1976-79	7.7	18.35	18.35
1980-85	7.8	18.5	18.5

¹ Additional costs of cash benefits are borne by employer-employee tax revenue because of 7 percent limitation on tax for underwriting cash benefits. Excess over 7 percent is attributable to financing medicare and catastrophic coverage.

Applying these various rates to the "maximum" tax base of \$7,800 (under present law) and \$9,000 under the bill would result in the following maximum tax:

MAXIMUM TAX ON BOTH EMPLOYER AND EMPLOYEE

Year	Under present law	Under the bill	Under the bill without \$100 minimum
1970.....	\$374.40		
1971.....	405.60	\$468.00	\$459.00
1972.....	405.60	495.00	486.00
1973-74.....	440.70	504.00	495.00
1975.....	440.70	571.50	571.50
1976-79.....	444.60	571.50	571.50
1980-85.....	452.40	630.00	630.00

MAXIMUM TAX ON SELF-EMPLOYED PERSONS

1970.....	\$538.20		
1971.....	585.00	\$666.00	\$657.00
1972.....	585.00	693.00	684.00
1973-74.....	596.70	702.00	693.00
1975.....	596.70	751.50	751.50
1976-79.....	600.60	751.50	751.50
1980-85.....	608.40	765.00	765.00

Although I believe that most people will be willing to pay increased taxes to assure cost-of-living increases in social security benefits, a reasonable degree of medicare coverage, and coverage under the catastrophic illness and disease program, we have reached the point of a taxpayers' revolt against tax increases which are used to fund low-priority and unnecessary, untimely, or inequitable social security benefits.

JACK MILLER.

XVII. SEPARATE VIEWS OF MR. JORDAN OF IDAHO

Provisions of this bill which are of overriding importance are those increasing social security benefits by 10% and increasing veterans pensions up to 9%. These increases are necessary to help social security beneficiaries and veteran pensioners to keep up with the rising cost of living which has been eroding the purchasing power of their fixed incomes. Regardless of the fate of the many and varied other provisions of the bill, it is essential that Congress act on these benefit increases.

The trade provisions, on the other hand, do not appear to me to be either necessary or desirable. I am not convinced that the beneficial effects claimed by the proponents of this legislation would not be greatly outweighed by the unfavorable consequences which it could bring about for the international trading position of the United States. The restrictive quota provisions may invite retaliation in kind from other nations, especially the Common Market nations and Japan. Such retaliation would seriously jeopardize U.S. exports, particularly agricultural exports.

In recent years a major contributor to our balance of payments and to national and regional economies has been agriculture. In fiscal year 1970 record commercial sales for dollars pushed total agricultural exports past the \$6.6 billion mark. U.S. exports to Japan alone reached \$1.09 billion in 1969/1970—the first time that such exports to a single country have surpassed the billion dollar level. The economy of my own State was boosted by about \$64 million in 1969/1970 through agricultural exports. American agriculture has achieved these results only through sustained and intensive work to develop and maintain foreign markets and we cannot afford to jeopardize these markets by enacting restrictive quota legislation.

XVIII. ADDITIONAL VIEWS OF MR. HANSEN ON THE TRADE ACT OF 1970

I support the Trade Act of 1970 as adopted by the Committee on Finance as an amendment to H.R. 17550.

The so-called Trade Act of 1970 has been misrepresented and misunderstood by the public media and by its opponents. It is not a highly restrictive, "protectionist" trade measure. On the contrary, it would achieve much needed reform in our current trade laws which would preserve American jobs for American labor and insure that industries which are suffering from excessive and unfair foreign competition will be given an opportunity to survive as viable entities in the United States. What does the Trade Act of 1970, as adopted by the committee, accomplish?

First, it revises our "escape clause" and "adjustment assistance provisions," very much along the lines that were proposed by Presidents Johnson and Nixon, so that industries, firms, and workers who are seriously or severely injured by increased imports could receive the relief to which they are entitled. Contrary to published reports the committee's amendment on tariff adjustment and adjustment assistance is completely compatible with international obligations of the United States and gives the President great flexibility in determining the adequate remedy.

Second, the Trade Act of 1970 would broaden the President's authority to deal with unfair trade practices including foreign subsidies, dumping or price discrimination and other discriminatory acts against American exporters.

Third, it would provide the President with tariff cutting authority of up to 20 percent to meet certain international obligations whenever an action on our part would affect a trade concession granted by the United States.

Fourth, it would impose quotas on textile and footwear articles *unless*:

(a) The President found that it was not in the national interest;

(b) The President found that such imports were not disrupting the United States market;

(c) The President found that such imports were needed to stem inflationary pressures; or

(d) The President was able to conclude voluntary agreements with foreign countries.

Thus, the quota provisions are entirely flexible and would likely never take effect if foreign countries reasonably regulated their exports of these sensitive products to the United States.

Fifth, the Trade Act of 1970 would establish the policy that whenever imports threaten to jeopardize the national security the President should impose quantitative restrictions (import quotas) to regu-

late such imports to a level commensurate with the preservation of the national security. I will go into more detail on this provision later in this statement.

Sixth, the Trade Act of 1970 would maintain the independence of the Tariff Commission from excessive executive influence and control, which is in keeping with the congressional intent for the establishment of the Tariff Commission in 1916.

Seventh, the Trade Act of 1970 would authorize and direct the President to conduct a number of thorough studies on the adequacy of international agreements and with respect to certain outstanding problems in the field of international trade.

Eighth, the Trade Act of 1970 gives the President a stronger negotiating position to achieve complete free trade in automobiles between the United States and Canada which was originally intended by the U.S.-Canadian Automobile Agreement.

Finally, the Trade amendment would: (a) require the Secretary of Commerce to provide more accurate statistics on foreign trade; (b) impose certain quantitative restrictions on mink and glycine; and (c) close a loophole in the current meat quota law.

I am particularly concerned with the national security provision of this bill which has been particularly maligned by its opponents. In the first place, let me describe what the provision accomplishes. Under present law, if the Director of the Office of Emergency Preparedness should find that imports of a particular commodity were threatening to impair the national security, he shall so report to the President who, if he agrees with the Director's finding, would have authority to take whatever action he deems necessary to adjust imports in order to safeguard the national security. In other words, the President has complete flexibility under the present statute.

There is much logic in the position that whenever a national security issue is involved because of imports, imports should be regulated in such a way as to prevent them completely inundating the domestic market and thus driving out United States productive capacity or severely impairing the ability of the domestic industry to meet our civilian and military needs in case the foreign source of the material was cut off. This implies that a certain amount of stability in the level of importations is necessary to accomplish the national security objective of the provision.

The degree of certainty cannot be provided by means of a tariff or duty. If the tariff was set too high it could shut out so much foreign supply that consumer interests would be hurt. On the other hand, if the tariff was set too low it would allow so much imports that domestic production and reserve capacity could be impaired and the national security endangered. There is no scientific approach to the setting of a tariff which would be so precise that it would regulate imports at just the right level to preserve the national security without jeopardizing the interest of American consumers. This is particularly true in the case of oil imports for reasons that I will describe below, but it is also true in the case of other imports which may be found to jeopardize the national security.

I am sure, for example, that if the footwear or textile industry brought a case to the Office of Emergency Preparedness and imports

of these products were found to impair the national security that its proponents would not be advocating a "scientific" tariff to regulate imports of footwear and textile articles. In the interest of "consumerism" they would want the assurance that imports would be set at a level reasonable enough to take a fair share of the market without driving the productive capacity in those industries out of this country. But many of the supporters of quotas for footwear and textile imports, are opponents of oil import quotas, and support a tariff scheme to regulate oil imports.

The opponents of the national security amendment argue that it will cost the American consumer billions of dollars. This is patently false, but even if it were not, one wonders whether their concern for "the consumer" includes those of us who wear shoes and clothing.

The Director of the Office of Emergency Preparedness, who was a member of the Cabinet Task Force on Oil Import Controls, unequivocally stated before the committee that *tariff rather than quotas* on oil would tend to drive up prices. He also informed us that it was a unanimous decision on the part of the Cabinet Committee dealing with oil imports that:

Recent developments have increased misgivings about moving to a tariff system at this time and about a tariff system as a feasible method of controlling oil imports.

The recent interruption in the flow of oil to Europe; while comparatively small in quantity, has caused significant disruption of the international oil situation.

Two other considerations are at least as important to me. First it appears that our country will be in a transitional situation for some time with regard to oil, if only because of the uncertainty as to the date Alaskan oil will be available and the effects of the environmental programs. Secondly, new estimates indicate we have a more severe problem than we estimated six months ago in preventing an unwise dependence on relatively insecure sources of supply by even as early as 1975.

The individual members of the Oil Policy Committee are impressed in varying ways by each of the three considerations mentioned above. All of us recognize that the method of control is a means to the national security end, which includes limiting U.S. dependence.

Because of these factors, the Oil Policy Committee concurs with my judgment that we discontinue consideration of moving to a tariff system of control, but rather continue with our efforts to improve the current program. (Page 287 of the committee hearing on the Trade Act of 1970.)

It is ironic to me that those who would advocate the imposition of import quotas to protect the domestic footwear, textile and dairy industries (without apparent regard to the consumer interests) would argue against import quotas on oil—the *only* commodity which has qualified under the national security provision of our trade laws. A recent high official in the U.S. Government has claimed that import quotas on textile and footwear articles will cost the American consumer \$3.7 billion a year. Proponents of quotas on these products will conveniently overlook this statement by a high U.S. official or will condemn it as misguided and erroneous thinking, while at the same time

latching on to equally if not more erroneous thinking with respect to the consumer effects of oil import controls.

The oil import program has been supported by four U.S. Presidents of both political parties—Presidents Eisenhower, Kennedy, Johnson, and Nixon. It is a necessary adjunct to preserve our ability to muster sufficient, secure sources of supply of this vital material to meet existing or potential civilian and military needs. President Kennedy was particularly concerned about this matter and he issued the proclamation which established a region formula for controlling oil imports. As President of all these United States, I believe he saw the need to protect the national interest and not to balkanize this country into warring regional producer and consumer interests, as some of the opponents of this program appear to be doing.

Finally, let me say that the national security provision would not in any way affect the President's flexibility to adjust the level of oil imports as he deems necessary. It does not "freeze" or "lock in" the present import program as its opponents contend.

CLIFFORD P. HANSEN.



Public Law 91-306 (H. R. 14720),
July 6, 1970 (Miscellaneous
OASDI amendments)



An Act

To continue until the close of June 30, 1973, the existing suspension of duties on manganese ore (including ferruginous ore) and related products, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) item 911.07 of the Tariff Schedules of the United States (19 U.S.C. 1202) is amended by striking out "6/30/70" and inserting in lieu thereof "6/30/73".

Manganese ore.
Duty suspension.
81 Stat. 119.

(b) The amendment made by subsection (a) shall apply with respect to articles entered, or withdrawn from warehouse, for consumption, after June 30, 1970.

SEC. 2. (a) (1) Section 1006 of the Social Security Amendments of 1969 is amended by—

OASDI and
railroad re-
tirement bene-
fit increase.
83 Stat. 741.
42 USC 415
note.
84 STAT., 407
84 STAT., 408
50 Stat. 307.
45 USC 228a-
228s-2.
49 Stat. 967.
45 USC 215-
228 notes.

(A) inserting "(1)" immediately after "paid to any individual";

(B) striking out "(1)" and inserting in lieu thereof "(A)";

(C) striking out "(2)" and inserting in lieu thereof "(B)"; and

(D) by inserting immediately before the period at the end thereof the following: "; or (2) as annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935, if such amount is paid in a lump-sum to carry out any retroactive increase in annuities or pensions payable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935 brought about by reason of the enactment (after May 30, 1970 and prior to December 31, 1970) of any Act which increases, retroactively, the amount of such annuities or pensions".

(2) The heading to such section 1006 is amended by inserting immediately before the period at the end thereof the following: "AND OF RAILROAD RETIREMENT BENEFIT INCREASE".

(b) (1) Section 1007 of the Social Security Amendments of 1969 is amended by—

OASDI and
railroad re-
tirement re-
cipients,
public assist-
ance.
83 Stat. 742.
42 USC 415
note.

(A) striking out "July 1970" and inserting in lieu thereof "November 1970";

(B) inserting "(1)" immediately after "also receives in such month";

(C) inserting immediately before the period at the end thereof the following: "; or (2) a monthly payment of annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935 which is increased as a result of the enactment (after May 30, 1970, and before December 31, 1970) of any Act which provides general increases in the amount of the annuities or pensions payable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935, the sum of the aid or assistance received by him for such month, plus the monthly amount of such annuity or pension received by him in such month (not including any part of such annuity or pension which is disregarded under section 1006), shall (except as otherwise provided in the succeeding sentence) exceed the sum of the aid or assistance which would have been received by him for such month under such plan as in effect for March 1970, plus the monthly annuity or pension which would have been received by him in such month without regard to the provisions of the Act enacted by such enactment, by an amount equal to \$4 or (if less) to such increase in his monthly annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935 (whether such

excess is brought about by disregarding a portion of such annuity or pension or other otherwise); and

(D) by adding at the end thereof the following new sentence: "If, in the case of any individual, the provisions of both clauses (1) and (2) of the preceding sentence are applicable to him with respect to any month, any increase in the annuity or pension (referred to in clause (2) of the preceding sentence) of such individual for such month shall, for purposes of such sentence, be treated as an additional increase in the amount of his monthly insurance benefit under title II of the Social Security Act for such month in lieu of an increase for such month in his annuity or pension (as so referred to)."

(2) The heading to such section 1007 is amended by inserting "AND RAILROAD RETIREMENT RECIPIENTS" immediately after "RECIPIENTS".

Approved July 6, 1970.

42 USC 401-
429.

83 Stat. 742.
42 USC 415
note.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 91-1077 (Comm. on Ways and Means).

SENATE REPORT No. 91-933 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 116 (1970):

May 19, considered and passed House.

June 19, considered and passed Senate, amended.

June 29, House concurred in Senate amendments.

Senate Report (Finance Com-
mittee) No. 91-933, June 16,
1970 (To accompany H. R.
14720) -- Excerpts from

Senate Report (Finance Committee)
No. 91-933, June 16, 1970 (To accom-
pany H. R. 14720) -- Excerpts from.

TREATMENT OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS FOR PUBLIC ASSISTANCE PURPOSES

Last December, the Congress enacted the Social Security Amendments of 1969 as title X of the Tax Reform Act of 1969. The amendments provided a 15-percent across-the-board increase in social security benefits. Though the benefit increase was to be effective beginning January 1970, the Social Security Administration was not able to complete its processing of the increase in benefits until March 1970. Thus it was understood that the 15-percent increase would first be reflected in checks received by beneficiaries early in April (the benefits payable for the month of March). It was further expected that the retroactive increase for the months of January and February would be mailed to beneficiaries in a separate check later in April.

The 1969 amendments also contained special provisions relating to the treatment of the social security benefit increase for public assistance purposes. Under section 1006 of the amendments, each State was required, in determining the need of its public assistance recipients, to disregard the retroactive payment of the social security benefit increase received in April.

Under section 1007 of the 1969 amendments, each State was also required, in determining the need of its public assistance recipients, to assure that every aged, blind, or disabled recipient who also received a

social security benefit increase under the bill would realize an increase in his combined income from public assistance and social security equal to \$4 a month. In other words, if an aged individual's social security benefits were increased by \$12 monthly, his public assistance could not be reduced more than \$8. The State was permitted to achieve this result either by disregarding a portion of the individual's social security benefit or by raising the State's standard of assistance for all recipients under the assistance program involved.

This requirement under the 1969 Amendments was made applicable only to the months before July 1970; it was thought that this would allow the Congress time to consider the problem more thoroughly in connection with its work on major welfare proposals this year.

In April the House of Representatives passed H.R. 16311, the Administration's proposed welfare legislation. One provision of this bill would have deleted the June 1970 limitation on the \$4 pass-along provisions continuing it as a requirement indefinitely.

The Committee on Finance began hearings on H.R. 16311 April 29, 1970. On May 1, the committee recessed its hearings to allow the Department of Health, Education, and Welfare an opportunity to revise the bill to correct its defects, and to put work incentive features into it. The Department of Health, Education, and Welfare has not yet sent up its complete revised welfare bill.

It is clear that the Congress will not be able to complete action on major welfare legislation by June 30. As a procedural matter, the committee recommends that the present \$4 pass-along provision be extended for 4 more months, through October 1970, to permit the committee and the Congress time to complete action on major welfare legislation.

In April of this year, the House of Representatives also passed H.R. 15733, a bill which would increase railroad retirement benefits by 15 percent, effective January 1970. It is the committee's view that the railroad retirement benefit increases should be treated for public assistance purposes in the same manner as the social security benefit increases. Accordingly, the committee amendment would:

- (1) Require States to disregard for public assistance purposes any retroactive payment of a railroad retirement benefit increase as may be provided under legislation enacted by the Congress this year;

- (2) Require States to increase by at least \$4 the combined income from railroad retirement benefits and public assistance for those aged, blind, and disabled welfare recipients who also receive railroad retirement benefits. This requirement, effective through October 1970, would accord the same treatment to railroad retirement beneficiaries as was given social security beneficiaries.

Public Law 91-669 (H. R. 19915),
January 11, 1971, An Act to
extend the temporary provision
for disregarding income of old-
age, survivors, and disability
insurance and railroad retirement
recipients in determining their
need for public assistance



Public Law 91-669
91st Congress, H. R. 19915
January 11, 1971

An Act

To extend the temporary provision for disregarding income of old-age, survivors, and disability insurance and railroad retirement recipients in determining their need for public assistance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled. That section 1007 of the Social Security Amendments of 1969, as amended by section 2(b) of Public Law 91-306, is amended to read as follows:

"SEC. 1007. In addition to the requirements imposed by law as a condition of approval of a State plan to provide aid to individuals under title I, X, XIV, or XVI of the Social Security Act, there is hereby imposed the requirement (and the plan shall be deemed to require) that, in the case of any individual found eligible (as a result of the requirement imposed by this section or otherwise) for aid for any month after March 1970 and before January 1972 who also receives in such month—

"(1) a monthly insurance benefit under title II of such Act, the sum of the aid received by him for such month, plus the monthly insurance benefit received by him in such month, shall not be less than the sum of the aid which would have been received by him for such month under the State plan as in effect for March 1970, plus either

"(A) the monthly insurance benefit which was or would have been received by him in March 1970 without regard to the other provisions of this title plus \$4, or

"(B) the monthly insurance benefit which was or would have been received by him in March 1970 under the provisions of this title,

whichever is less (whether this requirement is satisfied by disregarding a portion of his monthly insurance benefit or otherwise), or

"(2) a monthly payment of annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935, the sum of the aid received by him in such month, plus the monthly payment of such annuity or pension received by him in such month (not including any part of such annuity or pension which is disregarded under section 1006), shall (except as otherwise provided in the succeeding sentence) not be less than the sum of the aid which would have been received by him for such month under such plan as in effect for March 1970, plus either

"(A) the monthly payment of annuity or pension which was or would have been received by him in March 1970 without regard to the provisions of any Act enacted after May 30, 1970, and before December 31, 1970, which provides general increases in the amount of such monthly payment of annuity or pension plus \$4, or

OASDI and
railroad
retirement
recipients.
Public
assistance,
extension.
Ante, p. 408.
42 USC 301,
1201, 1351,
1381.
84 STAT. 2038
84 STAT. 2039.
42 USC 401.

50 Stat. 307.
45 USC 228a-
228s-2.
49 Stat. 967.
45 USC 215-
228 notes.
Ante, p. 407.

"(B) the monthly payment of annuity or pension which was or would have been received by him in March 1970, taking into account the provisions of such Act (if any), whichever is less (whether this requirement is satisfied by disregarding a portion of his monthly payment of annuity or pension or otherwise)."

Approved January 11, 1971.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 91-1716 (Comm. on Ways and Means).

CONGRESSIONAL RECORD, Vol. 116 (1970):

Dec. 22, considered and passed House.

Jan. 2, considered and passed Senate, amended; House agreed to Senate amendment.

House of Representatives Report
No. 91-1716 to accompany H. R.
19915

DISREGARDING OF OASDI AND RAILROAD RETIREMENT INCOME IN DETERMINING NEED FOR PUBLIC ASSISTANCE

DECEMBER 10, 1970.—Committed to the Committee of the Whole House on the
state of the Union and ordered to be printed.

Mr. MILLS, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 19915]

The Committee on Ways and Means, to whom was referred the bill (H.R. 19915) to make permanent the existing temporary provision for disregarding income of oldage, survivors, and disability insurance and railroad retirement recipients in determining their need for public assistance, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

PURPOSE OF H.R. 19915

The purpose of H.R. 19915 is to make permanent section 1007 of the Social Security Amendments of 1969. Section 1007 was a temporary provision that accompanied the 15-percent increase in social security benefits, the principal purpose of the Social Security Amendments of 1969.

Under section 1007, the States were required to take action to assure that recipients of public assistance under the federally aided adult public assistance programs (the old-age assistance, aid to the blind, and aid to the permanently and totally disabled programs) who also received a social security benefit increase under the 1969 amendments would realize an increase in combined income from public assistance and social security equal to \$4 a month or the amount of the social security benefit increase received by the recipient, if less. A State could meet this requirement either by disregarding a portion of the recipient's social security payment or by raising the State's standard of assistance for all recipients under the program involved.

Section 1007 of the 1969 amendments as originally enacted applied only to public assistance payments made before July 1970. The provision was enacted on a temporary basis in order to allow Congress time to consider the problem with which it dealt more thoroughly in connection with the work it has planned to do on major welfare proposals this year.

In April, the House of Representatives passed H.R. 16311, the administration's proposed welfare legislation. One of the sections of this bill provided for making section 1007 permanent law in the same manner as H.R. 19915.

In June of this year, when it became apparent that the Senate would not be able to complete action on H.R. 16311 before section 1007 was to expire, the Senate adopted an amendment to another pending bill (H.R. 14720) to extend the application of section 1007 through October of 1970. The Senate amendment also broadened section 1007 to apply to railroad retirement beneficiaries. The House agreed to this amendment and it was signed into law (Public Law 91-306).

The Senate has taken further action on this issue by including a provision to extend the application of section 1007 through December 31, 1971, in the pending Social Security Amendments of 1970 (H.R. 17550) which was ordered reported in the Senate on December 9.

Since section 1007 expired at the end of October and since both Houses of Congress have taken some action in the direction of extending its application to apply in the future, your committee believes it is imperative that action be taken on this legislation in order to prevent the States from ceasing to apply the provision, which in some instances could result in a \$4 reduction in public assistance payments for some recipients. H.R. 19915 would apply retroactively to public assistance payments for months since October 1970.

Your committee is unanimous in recommending enactment of H.R. 19915.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, existing law in which no change is proposed is shown in roman):

SECTION 1007 OF THE SOCIAL SECURITY AMENDMENTS OF 1969

SEC. 1007. DISREGARDING OF INCOME OF OASDI RECIPIENTS AND RAILROAD RETIREMENT RECIPIENTS IN DETERMINING NEED FOR PUBLIC ASSISTANCE

In addition to the requirements imposed by law as a condition of approval of a State plan to provide aid or assistance in the form of money payments to individuals under title I, X, XIV, or XVI of the Social Security Act, there is hereby imposed the requirement (and the plan shall be deemed to require) that, in the case of any individual receiving aid or assistance for any month after March 1970 [and before

November 1970] who also receives in such month (1) a monthly insurance benefit under title II of such Act which is increased as a result of the enactment of the other provisions of this title, the sum of the aid or assistance received by him for such month, plus the monthly insurance benefit received by him in such month (not including any part of such benefit which is disregarded under section 1006), shall exceed the sum of the aid or assistance which would have been received by him for such month under such plan as in effect for March 1970, plus the monthly insurance benefit which would have been received by him in such month without regard to the other provisions of this title, by an amount equal to \$4 or (if less) to such increase in his monthly insurance benefit under such title II (whether such excess is brought about by disregarding a portion of such monthly insurance benefit or otherwise), or (2) a monthly payment of annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935 which is increased as a result of the enactment (after May 30, 1970, and before December 31, 1970) of any Act which provides general increases in the amount of the annuities or pensions payable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935, the sum of the aid or assistance received by him for such month, plus the monthly amount of such annuity or pension received by him in such month (not including any part of such annuity or pension which is disregarded under section 1006), shall (except as otherwise provided in the succeeding sentence) exceed the sum of the aid or assistance which would have been received by him for such month under such plan as in effect for March 1970, plus the monthly annuity or pension which would have been received by him in such month without regard to the provisions of the Act enacted by such enactment, by an amount equal to \$4 or (if less) to such increase in his monthly annuity or pension under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1935 (whether such excess is brought about by disregarding a portion of such annuity or pension or otherwise). If, in the case of any individual, the provisions of both clauses (1) and (2) of the preceding sentence are applicable to him with respect to any month, any increase in the annuity or pension (referred to in clause (2) of the preceding sentence) of such individual for such month shall, for purposes of such sentence, be treated as an additional increase in the amount of his monthly insurance benefit under title II of the Social Security Act for such month in lieu of an increase for such month in his annuity or pension (as so referred to).



Public Law 91-690 (H. R. 19470),
January 12, 1971, An Act to
modify the nursing service re-
quirement and certain other
requirements



Public Law 91-690
91st Congress, H. R. 19470
January 12, 1971

An Act

84 STAT. 2074

To amend title XVIII of the Social Security Act to modify the nursing service requirement and certain other requirements which an institution must meet in order to qualify as a hospital thereunder so as to make such requirements more realistic insofar as they apply to smaller institutions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 1861 (e) (5) of the Social Security Act is amended by adding immediately after the semicolon at the end thereof the following: "except that until January 1, 1976, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

"(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

"(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

"(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;"

Approved January 12, 1971.

Nursing service
requirements,
modification.
79 Stat. 315.
42 USC 1395x.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 91-1676 (Comm. on Ways and Means).
CONGRESSIONAL RECORD, Vol. 116 (1970):

Dec. 22, considered and passed House.

Dec. 31, considered and passed Senate.

House of Representatives
Report No. 91-1676 to
accompany H. R. 19470.
Report of Committee on
Ways and Means

REASONABLE APPROVAL OF RURAL HOSPITALS FOR MEDICARE PURPOSES

DECEMBER 7, 1970.—Ordered to be printed

Mr. BURLSON, of Texas, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 19470]

The Committee on Ways and Means, to whom was referred the bill (H.R. 19470) to amend title XVIII of the Social Security Act to modify the nursing service requirement and certain other requirements which an institution must meet in order to qualify as a hospital thereunder so as to make such requirements more realistic insofar as they apply to smaller institutions, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert the following:

That section 1861(e)(5) of the Social Security Act is amended by adding immediately after the semicolon at the end thereof the following:

“except that until January 1, 1976, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of 24-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

“(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

“(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

“(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;”.

PURPOSE

The purpose of H.R. 19470, as amended, is to permit certain hospitals which have had difficulty in securing required nursing services to continue to participate in the medicare program for up to 5 years under specified conditions.

GENERAL STATEMENT

According to policy established by the Social Security Administration, a hospital or extended care facility is certified for participation in medicare if it is in full compliance (meets all the requirements of the Social Security Act and is in accordance with all regulatory requirements for participation), or if it is in "substantial" compliance (meets all the statutory requirements and the most important regulatory conditions for participation). Thus, while an institution may be deficient with respect to one or more standards of participation, it may still be found to be in substantial compliance, if the deficiencies do not represent a hazard to patient health or safety, and efforts are being made to correct the deficiencies.

It has been recognized that there is a need to assure continuing availability of medicare-covered institutional care in rural areas, many of which may have only one hospital, without jeopardizing the health and safety of patients. To achieve this objective, the approach has been adopted by Social Security of certifying "access" hospitals while documenting their deficiencies and requiring upgrading of plant and staff. State agencies have also been required to provide consultation and assistance to these facilities in an effort to help them achieve compliance with the standards. Certain "access" hospitals, to the extent that they are capable, have succeeded in overcoming deficiencies. However, many hospitals have not demonstrated sufficient willingness to take the steps necessary to correct deficiencies and have instead been willing to continue as "access" hospitals with all the limitations in quality care that this status entails. In other areas, some rural hospitals despite proper efforts have been unable to secure required personnel or otherwise comply.

To deal with the dilemma created by the need to assure the availability of hospital services of adequate quality in rural areas and the fact that existing shortages of qualified nursing personnel make it difficult for some rural hospitals to meet the nursing staff requirements of present law, your committee's bill would authorize the Secretary, under certain conditions, to waive the requirement that an access hospital have registered professional nurses on duty around the clock. This requirement could be waived only if the Secretary finds that the hospital:

(a) Has at least one registered nurse on the day shift and has made, and is continuing to make, a bona fide effort to comply with the registered nursing staff requirement with respect to other shifts (which, in the absence of an R.N. are covered by licensed practical nurses) but is unable to employ the qualified personnel necessary, at prevailing wage or salary levels, because of nursing personnel shortages in the area;

(b) Is located in an isolated geographical area in which hospitals are in short supply and the closest other participating hospitals are not readily accessible to people of the area; and

(c) Nonparticipation of the "access" hospital would seriously reduce the availability of hospital services to medicare beneficiaries residing in the area.

Under the provision, the Secretary would regularly review the situation with respect to each hospital, and the waiver would be granted on an annual basis for not more than one-year at a time. The waiver authority would be applicable only with respect to the nursing staff requirement; no waiver authority would be provided under the amendment with respect to any other conditions of participation or any standards relating to health and safety.

The proposed waiver authority would expire December 31, 1975.

Your committee is unanimous in recommending the enactment of this bill.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in *italic*, existing law in which no change is proposed is shown in roman):

SECTION 1861(e) OF THE SOCIAL SECURITY ACT

DEFINITION OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

(a) * * *

* * * * *

HOSPITAL

(e) The term "hospital" (except for purposes of sections 1814(d) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; *except that until January 1, 1976, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of 24-hour nursing service rendered or supervised by a registered*

professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area,

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and

(8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals (subject to the second sentence of section 1863).

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), and subsections (i) and (n) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass., but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under

such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865.

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APPENDIX

The following is a listing of the acts contained in the preceding volumes of this legislative history:

Volume I 74th-76th Congress

- Act of August 14, 1935 (Public, No. 271, 74th Congress; 49 Stat. 620). The Social Security Act.
- Act of August 10, 1939 (Public, No. 379, 76th Congress; 53 Stat. 1360). The Social Security Act Amendments of 1939.
- Act of August 11, 1939 (Public, No. 400, 76th Congress; 53 Stat. 1420) - providing for the noncollection of FICA tax on certain services rendered before January 1940.
- Act of August 13, 1940 (Public, No. 764, 76th Congress; 54 Stat. 785) - providing for more uniform coverage for certain persons employed in coal mining operations.

Volume II 78th-80th Congress

- Act of March 24, 1943 (Public Law 17, 78th Congress; 57 Stat. 45) - services of officers and members of crews employed by War Shipping Administration; maritime tax deduction.
- Act of February 25, 1944 (Public Law 235, 78th Congress; 58 Stat. 21). The Revenue Act of 1943.
- Act of April 4, 1944 (Public Law 285, 78th Congress; 53 Stat. 188) - clarifying provisions of Act of March 24, 1943.
- Act of October 23, 1945 (Public Law 201, 79th Congress; 59 Stat. 546) - services of employees of the Bonneville Power Administration.
- Act of December 29, 1945 (Public Law 291, 79th Congress; 59 Stat. 669). The International Organizations Immunities Act.
- Act of July 31, 1946 (Public Law 572, 79th Congress; 60 Stat. 722) - crediting railroad industry service under the Social Security Act.
- Act of August 8, 1946 (Public Law 671, 79th Congress; 60 Stat. 925) - employment for business vested in or transferred to Alien Property Custodian.

Act of August 10, 1946 (Public Law 719, 79th Congress; 60 Stat. 978). The Social Security Act Amendments of 1946.

Act of April 20, 1948 (Public Law 492, 80th Congress; 62 Stat. 195) - to exclude certain vendors of newspapers and magazines.

Act of June 14, 1948 (Public Law 642, 80th Congress; 62 Stat. 438) - usual common-law rules applicable in determining employer-employee relationship.

Volume III 81st Congress

Act of August 28, 1950 (Public Law 734, 81st Congress; 64 Stat. 477). The Social Security Act Amendments of 1950.

Act of September 23, 1950 (Public Law 814, 81st Congress; 64 Stat. 906). The Revenue Act of 1950.

Volume IV 82nd-83rd Congress

Act of July 12, 1951 (Public Law 78, 82d Congress; 65 Stat. 119) - exclusion of service performed by Mexican agricultural workers, admitted under Title V of the Agricultural Act of 1949.

Act of October 30, 1951 (Public Law 234, 82d Congress; 65 Stat. 683) - interrelationship between RRA and SSA.

Act of June 28, 1952 (Public Law 420, 82d Congress; 66 Stat. 285) - amending sec. 218(f) of the Act.

Act of July 18, 1952 (Public Law 590, 82d Congress; 66 Stat. 767). The Social Security Act Amendments of 1952.

Act of August 14, 1953 (Public Law 269, 83d Congress; 67 Stat. 580) - providing for wage credits for military service before July 1, 1955.

Act of August 15, 1953 (Public Law 279, 83d Congress; 67 Stat. 587) - adding section 218(m) relating to services of employees in positions covered by Wisconsin retirement fund.

Act of September 1, 1954 (Public Law 761, 83d Congress; 68 Stat. 1052). The Social Security Amendments of 1954.

Volume V 84th Congress

Act of August 9, 1955 (Public Law 325, 84th Congress; 69 Stat. 621) - providing for wage credits for military service before April 1956; extending time for filing lump sum applications in certain cases.

Act of August 1, 1956 (Public Law 880, 84th Congress; 70 Stat. 807). The Social Security Amendments of 1956.
Act of August 1, 1956 (Public Law 881, 84th Congress; 70 Stat. 857). The Servicemen's and Veterans' Survivor Benefits Act.

Volume VI 85th Congress

Act of July 17, 1957 (Public Law 85-109, 85th Congress; 71 Stat. 308) - amending sec. 216(i) and sec. 224(e) of the Act.

Act of August 30, 1957 (Public Law 85-226, 85th Congress; 71 Stat. 511) - amending sec. 218(f), (k), and (p) of the Act.

Act of August 30, 1957 (Public Law 85-227, 85th Congress; 71 Stat. 512) - amending sec. 218(d)(6) of the Act.

Act of August 30, 1957 (Public Law 85-229, 85th Congress; 71 Stat. 513) - adding new paragraph (7) to sec. 218(d) of the Act.

Act of August 30, 1957 (Public Law 85-238, 85th Congress; 71 Stat. 518) - amending sec. 202(b), (c), (e)-(h), (p) and (t), and sec. 216(h) of the Act, and secs. 1(q) and 5(l) of the RRA.

Act of August 30, 1957 (Public Law 85-239, 85th Congress; 71 Stat. 521) - extending the time within which a minister can elect coverage and amending sec. 211(a)(7) of the Act.

Act of August 27, 1958 (Public Law 85-785, 85th Congress; 72 Stat. 938) - to provide coverage for certain employees of tax exempt organizations which failed to file waiver certificates.

Act of August 27, 1958 (Public Law 85-786, 85th Congress; 72 Stat. 938) - providing that the sec. 209(i) exception from wages does not apply to payments to State and local employees absent from work because of sickness.

Act of August 27, 1958 (Public Law 85-787, 85th Congress; 72 Stat. 939) - amending sec. 218(d)(6) by adding Massachusetts and Vermont and permitting a "second chance" to choose coverage in certain cases.

Act of August 28, 1958 (Public Law 85-798, 85th Congress; 72 Stat. 964) - providing for re-entitlement for certain widows - sec. 202(g); coverage for policemen and firemen working for interstate instrumentalities - sec. 218(k); and coverage of policemen and firemen in State of Washington - sec. 218(p).

- Act of August 28, 1958 (Public Law 85-840, 85th Congress; 72 Stat. 1013). The Social Security Amendments of 1958.
- Act of September 2, 1958 (Public Law 85-857, 85th Congress; 72 Stat. 1105) - interrelationship between title 11 of the Social Security Act and title 38 U.S.C. - Veterans Benefits.
- Act of September 6, 1958 (Public Law 85-927, 85th Congress; 72 Stat. 1778) - amending RRA and sec. 202(t) of the Social Security Act.

Volume VII 86th Congress, Part 1

- Act of June 25, 1959 (Public Law 86-70, 86th Congress; 73 Stat. 141). The Alaska Omnibus Act.
- Act of August 18, 1959 (Public Law 86-168, 86th Congress; 73 Stat. 384) - providing that the sec. 210(a)(6)(B) exclusion does not apply to service performed in the employ of a Federal land bank, a Federal intermediate credit bank or a bank for cooperatives.
- Act of September 16, 1959 (Public Law 86-284, 86th Congress; 73 Stat. 566) - amending sec. 104(f), Social Security Amendments of 1956 and sec. 218(p) and extending the time for modifying certain State agreements.
- Act of September 22, 1959 (Public Law 86-346, 86th Congress; 73 Stat. 621) - amending sec. 201(d) of the Act.
- Act of April 8, 1960 (Public Law 86-415, 86th Congress; 74 Stat. 32) - remuneration of Public Health Service Reserve Corp commissioned officers; waiver of benefits.
- Act of April 22, 1960 (Public Law 86-442, 86th Congress; 74 Stat. 81) - amending sec. 213(a)(2)(B) of the Act - quarters of coverage based on wages earned.
- Act of June 11, 1960 (Public Law 86-507, 86th Congress; 74 Stat. 200) - amending sec. 205(d) of the Act.
- Act of July 12, 1960 (Public Law 86-624, 86th Congress; 74 Stat. 411). The Hawaii Omnibus Act.

Volume VIII 86th Congress, Part 2

- Act of September 13, 1960 (Public Law 86-778, 86th Congress; 74 Stat. 924). The Social Security Amendments of 1960.

Volume IX 87th Congress

- Act of June 30, 1961 (Public Law 87-64, 87th Congress; 75 Stat. 131). The Social Security Amendments of 1961.
- Act of September 21, 1961 (Public Law 87-256, 87th Congress; 75 Stat. 527). The Mutual Educational and Cultural Exchange Act of 1961.
- Act of September 21, 1961 (Public Law 87-262, 87th Congress; 75 Stat. 542) - continuing the sec. 210(a)(6) exclusion of services of employees of Freedman's Hospital who transfer to Howard University.
- Act of September 22, 1961 (Public Law 87-293, 87th Congress; 75 Stat. 612). The Peace Corps Act.
- Act of October 5, 1961 (Public Law 87-397, 87th Congress; 75 Stat. 828) - permitting the use of social security account numbers as identifying numbers for income tax purposes.
- Act of October 24, 1962 (Public Law 87-878, 87th Congress; 76 Stat. 1202) - validating coverage of certain State and local employees in Arkansas and adding "Maine" in sec. 218(p) of the Act.

Volume X 88th Congress

- Act of February 26, 1964 (Public Law 88-272, 88th Congress; 78 Stat. 19). The Revenue Act of 1964.
- Act of July 2, 1964 (Public Law 88-350, 88th Congress; 78 Stat. 240) - extending the time within which teachers and other employees covered by the same retirement system in the State of Maine may be treated as being covered by separate retirement systems for purposes of the old-age, survivors, and disability insurance program.
- Act of July 23, 1964 (Public Law 88-382, 88th Congress; 78 Stat. 335) - permitting Nevada to divide its retirement systems into two parts for purposes of obtaining social security coverage under its Federal-State agreement.
- Act of August 20, 1964 (Public Law 88-452, 88th Congress; 78 Stat. 508). The Economic Opportunity Act of 1964.
- Act of October 13, 1964 (Public Law 88-650, 88th Congress; 78 Stat. 1075) - providing full retroactivity for disability determinations, extending the period within which ministers may elect coverage, validating certain wages reported, and making certain other changes.

Volume XI 89th Congress

Act of July 30, 1965 (Public Law 89-97, 89th Congress; 79 Stat. 286). The Social Security Amendments of 1965.

Act of March 15, 1966 (Public Law 89-368, 89th Congress; 80 Stat. 67). The Tax Adjustment Act of 1966 - providing benefits at age 72 for certain uninsured individuals.

Act of April 8, 1966 (Public Law 89-384, 89th Congress, 80 Stat. 99) - extending the initial enrollment period for supplementary medical insurance benefits.

Act of November 2, 1966 (Public Law 89-713, 89th Congress, 80 Stat. 1107) - relating to the reasonable cost for reimbursement of proprietary extended care facilities under Health Insurance for the Aged.

Volume XII 90th Congress

Act of September 30, 1967, to extend through March 1968 the first general enrollment period under part B of title XVIII of the Social Security Act (relating to supplementary medical insurance benefits for the aged), and for other purposes (Public Law 90-97, 90th Congress, H.R. 13026).

Act of January 2, 1968, to amend the Social Security Act to provide an increase in benefits under the old-age, survivors, and disability insurance system, to provide benefits for additional categories of individuals, to improve the public assistance program and programs relating to the welfare and health of children, and for other purposes (Public Law 90-248, 90th Congress, H.R. 12080). The Social Security Amendments of 1967.

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